Reference Guide for Medicare Institutional Providers Who Submit Part B Claims

Helping Front Office Personnel Navigate Medicare Rules for Part B Claims Processing

First Edition 2006

REFERENCE GUIDE FOR MEDICARE INSTITUTIONAL PROVIDERS WHO SUBMIT PART B CLAIMS

HELPING FRONT OFFICE PERSONNEL NAVIGATE MEDICARE RULES FOR PART B CLAIMS PROCESSING

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DISCLAIMER

This guide was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at *www.cms.hhs.gov/MLNGenInfo* on the CMS website.

FOREWORD

The Centers for Medicare & Medicaid Services (CMS) is focused along three primary lines of service:

- **The Center for Medicare Management** - manages traditional fee-for-service Medicare to include development of payment policy and management of the Medicare fee-for-service contractors;
- **The Center for Beneficiary Choices** - provides beneficiaries with information on Medicare, Medicare Select, Medicare Advantage, and Medigap options to include management of the Medicare Advantage Plans, consumer research and demonstrations, and grievance and appeals functions; and
- **The Center for Medicaid and State Operations** - manages programs administered by states to include Medicaid, the State Children's Health Insurance Programs (SCHIP), insurance regulation functions, survey and certification, and the Clinical Laboratory Improvement Amendments (CLIA).

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), signed into law on December 8, 2003, is currently being implemented. This law and other proposed regulations provide a new voluntary drug benefit and enhanced health plan choices within Medicare Advantage. As a result of these new benefits, beneficiaries can obtain voluntary drug coverage and new support for their existing drug coverage through Medicare, and they can gain access to Preferred Provider Organizations (PPOs).

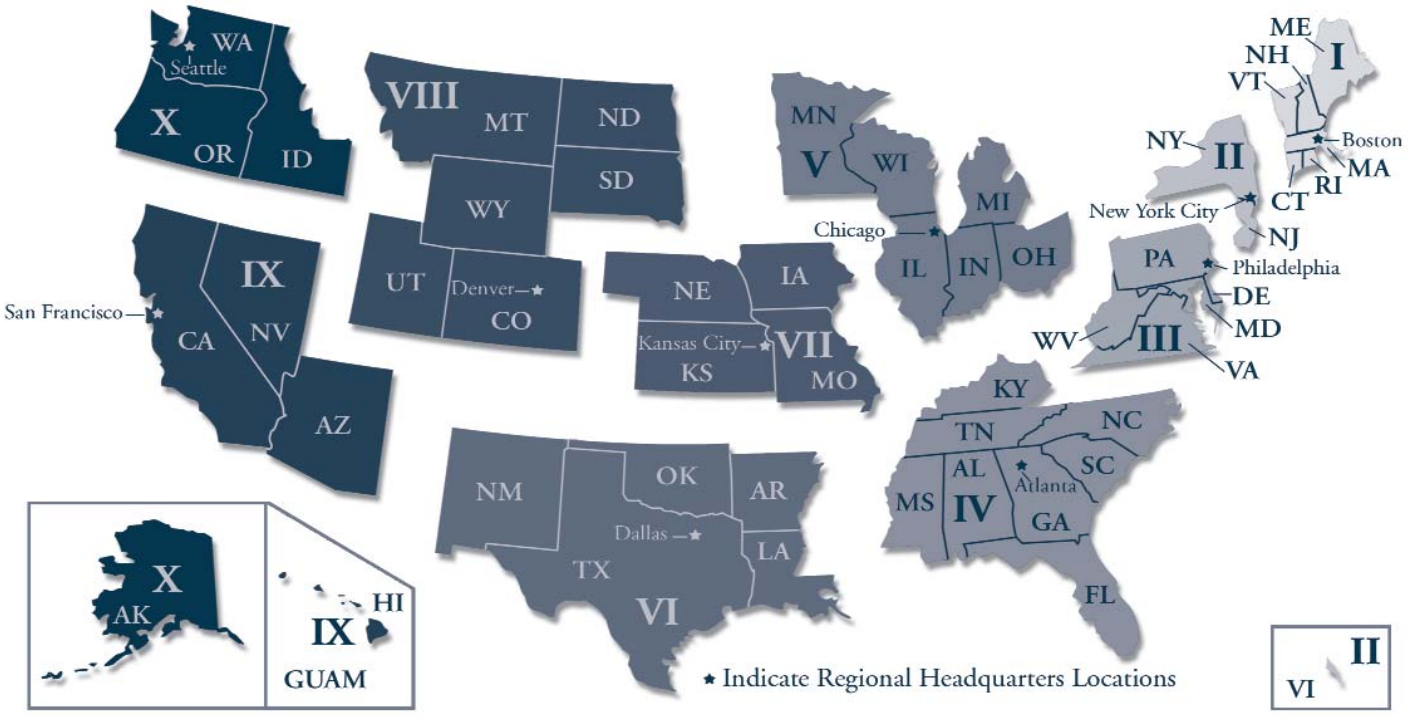
Through the MMA benefit, beneficiaries can choose how they want to get their outpatient drug coverage. Prescription drug plans and Medicare Advantage Plans will be required to provide basic coverage, but may also offer additional plans with supplemental coverage. Such "high option" plans with enhanced coverage (for example, covering 75% of drug spending without any gap in coverage) allow beneficiaries to add to the Medicare-subsidized coverage using some of the contributions that beneficiaries, health plans, employers, unions, and others are making today. Charitable organizations, other individuals, and states will also be able to contribute to beneficiary out-of-pocket costs while still having their contributions count as "true out-of-pocket" spending for purposes of the Medicare subsidy for high drug expenses.

Where Is CMS Located?

The CMS Central Office is located in Baltimore, Maryland. The following 10 Regional Offices, shown with their associated region codes, provide policy guidance to Medicare Contractors:

- Boston [I]
- New York [II]
- Philadelphia [III]
- Atlanta [IV]
- Chicago [V]
- Dallas [VI]
- Kansas City [VII]
- Denver [VIII]
- San Francisco [IX]
- Seattle [X]

The figure below shows how each CMS region is defined by state and/or territory:



Regional Office Contact Information

To access contact information for each Regional Office, please visit the CMS Regional Offices website at *www.cms.hhs.gov/RegionalOffices* on the CMS website.

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PREFACE

DISCLAIMER

This guide addresses the submission of Medicare Part B claims by Medicare institutional providers. For the purposes of this guide, references to the term "provider" generally apply to all hospitals, Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), hospital-based clinics, Outpatient Rehabilitation Facilities (ORFs), and other Part A institutional providers, unless otherwise specified.

What is an Institutional Medicare Provider?

Institutional providers are institutions that furnish inpatient and/or medical services to Medicare beneficiaries. These include: hospitals; Skilled Nursing Facilities (SNFs); Home Health Agencies (HHAs); Comprehensive Outpatient Rehabilitation Facilities (CORFs); End Stage Renal Disease (ESRD) facilities; hospice agencies; Outpatient Therapy Facilities (OTFs); and other facilities. When enrolled, an institutional provider submits claims to Fiscal Intermediaries (FIs) or Regional Home Health Intermediaries (RHHIs). Institutional providers often furnish and submit claims for Part B services; however, the specific procedures for submitting claims described in this guide differ from those of Part B providers (physicians and suppliers).

Institutional provider billing offices (e.g., hospitals) are responsible for submitting claims to Carriers for certain services if they are enrolled as both an institutional provider and as a Part B supplier. Many institutional providers enroll as Part B suppliers to submit claims for the services of physicians and other practitioners. The companion *Reference Guide for Medicare Physician & Supplier Billers*, available at *www.cms.hhs.gov/MLNProducts* on the CMS website, provides guidance for submitting such claims to Carriers.

What Information Is Included Within this Guide?

This guide contains a variety of information to help institutional providers submit accurate and timely Medicare claims. While providing historical information on Medicare Part A, Medicare Advantage, and a brief introduction to the new Medicare Part D drug coverage benefits, this guide is focused on providing information and procedures for institutional entities that provide Part B services in addition to, or instead of, Part A services. This guide is divided into the following sections and contains reference sections at the end of the guide:

Section 1 - Introduction to Medicare

Provides an overview of the Medicare Program, describing what it is, who manages and administers the program, eligibility requirements, and coverage provisions.

Section 2 - Becoming a Medicare Provider

Provides an introduction to the general rules for participating as a Medicare provider. It explains the types of providers, instructions for enrollment and updating provider information, common enrollment questions and answers, and information regarding reimbursement.

Section 3 - Submitting Medicare Claims

Provides an overview of how to submit an electronic or a paper Medicare claim and Medicare Secondary Payer (MSP) submission policies.

Section 4 - Introduction to the Medical Review (MR) Process

Provides an overview of the MR process and the effects of Medicare policy development.

Section 5 - Protecting Medicare from Fraud and Abuse

Provides an overview of the Progressive Corrective Action (PCA) process and ways to identify and prevent Medicare fraud and abuse.

Section 6 - Troubleshooting Denials and Claim Rejections

Explains numerous billing and data entry errors and provides methods for a provider to avoid such errors and submit Medicare claims accurately to avoid denied claims.

Section 7 - Appealing Medicare Claim Denials

Provides an overview of the Medicare claim appeals process.

Section 8 - Introduction to HIPAA

Provides an overview of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that protects health insurance coverage for workers and their families, establishes national standards for electronic health care transactions, and protects security and privacy of health data.

Reference A Form CMS-1450 (UB-92)

Contains a template of Form CMS-1450 (UB-92) claim form submitted to Fiscal Intermediaries (FIs) and instructions for completing the form.

Reference B Form CMS-1450 Electronic Claim Format Crosswalk

Contains a crosswalk that matches Form CMS-1450 paper claim blocks to the corresponding electronic claim Field Locators (FLs).

Reference C Type of Bill (TOB) Codes

Contains a list of TOB Codes used on Form CMS-1450 during claims submission.

Reference D Condition Codes

Contains a list of Condition Codes used on Form CMS-1450 during claims submission.

Reference E Value Codes and Amounts

Contains a list of Value Codes and amounts used on Form CMS-1450 during claims submission.

Reference F Revenue Codes

Contains a list of Revenue Codes used on Form CMS-1450 during claims submission.

Reference G Relationship Codes

Contains a list of Relationship Codes used on Form CMS-1450 during claims submission.

Reference H Occurrence and Occurrence Span Codes

Contains a list of Occurrence and Occurrence Span Codes used on Form CMS-1450 during claims submission.

Reference I Glossary

Contains a list of terms used throughout this document.

Reference J Acronyms

Contains a list of acronyms used throughout this document.

Reference K Websites and Phone Numbers

Contains a list of websites and phone numbers that are referenced throughout this document.

The Medicare Program is currently the world's largest health insurance program. When Medicare began on July 1, 1966, approximately 19 million individuals enrolled. By 2003, over 41 million individuals were enrolled in one or both parts of the Medicare Program (known as Part A and Part B), and 5 million of them chose to participate in a Medicare Advantage Plan, commonly referred to as Part C. Medicare also establishes guidelines for Medigap plans that help pay for deductibles, coinsurance amounts, copayments, and other costs not covered by Medicare. As of 2006, Medicare offers a new prescription drug benefit (Part D) through private insurance companies. Congress has established specific rules regarding how various beneficiary health insurance plans are coordinated so that Medicare payments are issued fairly and equitably.

WHAT IS MEDICARE?

Title XVIII of the Social Security Act, designated "Health Insurance for the Aged and Disabled," is commonly known as Medicare. As part of the Social Security Amendments of 1965, Medicare legislation established a health insurance program for aged individuals to complement the retirement, survivor, and disability insurance benefits under Title II of the Social Security Act. When first implemented in 1966, Medicare covered most individuals age 65 or over. In 1973, the following groups also became eligible for Medicare benefits:

- Individuals entitled to Social Security or Railroad Retirement disability cash benefits for at least 24 months
- Individuals with End Stage Renal Disease (ESRD)
- Certain otherwise non-covered aged individuals who elect to pay a premium for Medicare coverage

Medicare has traditionally consisted of two parts: Part A and Part B. A newer, third part of Medicare, sometimes known as Part C, is the Medicare Advantage Plan. This plan is available to individuals who qualify for Medicare. Medicare Advantage was established by the Balanced Budget Act of 1997 (BBA) (Public Law 105-33) and expanded beneficiaries' options for participation in private-sector health care plans.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) legislation provides seniors and individuals living with disabilities with a prescription drug benefit, additional choices, and enhanced benefits under Medicare (including new preventive services under Part B). Most notably, the MMA provides Medicare beneficiaries with opportunities for discounts on their prescription drugs during 2004 and 2005, as well as voluntary comprehensive Medicare prescription drug coverage, effective January 1, 2006. This drug coverage, known as Medicare Part D, is provided by private health plans. This coverage can be a stand-alone drug benefit for individuals eligible for Medicare, or can be provided through a Medicare Advantage Plan that offers comprehensive benefits.

New Medicare Law and Drug Card Information

Current details about the 2003 Medicare legislation and related policies may be found at *www.cms.hhs.gov/MMAupdate* on the CMS website. If a Medicare beneficiary raises questions about the Discount Drug Card, he or she should call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-800-486-2048. The beneficiary could also visit *www.medicare.gov* on the Web and select "Prescription Drug and Other Assistance Programs," or visit *www.cms.hhs.gov/PrescriptionDrugCovGenIn/03_Resources.asp* on the CMS website.

UNDERSTANDING THE MEDICARE PART A BENEFIT

Medicare Part A, referred to as "Hospital Insurance," helps cover services and supplies related to inpatient hospital stays, Skilled Nursing Facility (SNF) care following a related, covered 3-day hospital stay, some home health care, and hospice care for the terminally ill. The Social Security Administration (SSA) will determine if an individual must pay a premium for Medicare Part A, but most beneficiaries do not pay a premium because they (or a spouse) paid Medicare taxes while they were working.

A provider can determine if a beneficiary has Medicare Part A benefits by looking at the beneficiary's red, white, and blue Medicare Health Insurance card (see Figure 1-1). *Earlier versions of this card may appear differently than the card shown in Figure 1-1; however, the earlier versions are still valid.*

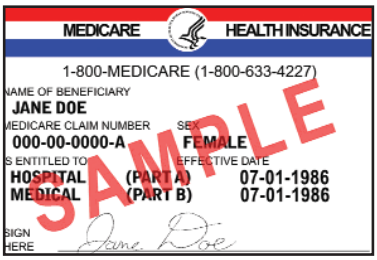


Figure 1-1. Medicare Identification Card

If the beneficiary's Medicare Health Insurance card says "Hospital (Part A)," he or she is entitled to Part A benefits.

If a beneficiary qualifies for inpatient hospital care, services covered by Medicare Part A include the following:

- A semiprivate room
- Meals
- Blood transfusions
- General nursing
- Medications administered during the inpatient stay
- Special care units, such as intensive or coronary care
- Other hospital services and supplies

This includes care in Critical Access Hospitals (CAHs) and inpatient mental health care in an independent psychiatric facility. Coverage does **NOT** include private-duty nursing, an in-room television or telephone, or a private room (unless a private room is deemed medically necessary).

If a patient qualifies for SNF care, services covered by Medicare Part A include the following:

- A semiprivate room
- Meals
- Blood transfusions
- Skilled nursing and rehabilitative services
- Medical social services

- Medications and medical supplies and equipment used in the facility
- Some ambulance transportation (when other transportation would endanger health) to the nearest provider of needed services not available at the SNF
- Dietary counseling
- Other services that SNFs generally furnish such as laboratory tests and X-rays

To be eligible for home health care, a beneficiary must meet all of the following four conditions:

- A doctor must decide that the beneficiary needs medical care in his or her home and must create a plan for home health care for that beneficiary.
- The beneficiary must need at least one of the following:
  - Intermittent (not full time) skilled nursing care
  - Physical therapy
  - Speech language pathology services
    - Continuing occupational therapy
- The beneficiary must be homebound (unable to leave home or leaving home is a major effort). If the patient does leave the house, he or she may continue to be considered homebound if the absences are infrequent or for periods of short duration, or are to receive health care treatment. This may include regular absences to participate in therapeutic, psychological, or medical treatment in an adult day-care program that is approved by the state.
- The Home Health Agency (HHA) that provides the care must be Medicare approved.

Occupational Therapy at Home

Services provided by an occupational therapist under the home health benefit may only be provided once the home health episode has been established by either intermittent skilled nursing, physical therapy, or speech language pathology. Once services are established in the home, occupational therapy becomes a qualifying discipline and may remain in the home as long as occupational therapy services are required and the patient meets all of the eligibility criteria.

If a beneficiary qualifies for home health care, services covered by Medicare Part A for each 60-day episode of care include the following:

- Intermittent (not full-time) skilled nursing care
- Physical therapy
- Occupational therapy
- Speech language pathology
- Home health aide services
- Medical supplies such as wound dressings (but NOT prescription drugs)
- Durable Medical Equipment (DME) such as wheelchairs, hospital beds, oxygen, and walkers
- Medical social services

If a beneficiary qualifies for hospice care, services covered by Medicare Part A in “periods of care” (i.e., two 90-day periods followed by 60-day periods as needed) include the following:

- Doctor services (nurse practitioners and hospice facilities should note that nurse practitioners are being added to the definition of an attending physician for beneficiaries who have elected the hospice benefit)
- Nursing care

- Durable Medical Equipment (DME), such as wheelchairs and walkers
- Medical supplies such as bandages and catheters
- Drugs for symptom control and pain relief
- Short-term hospital and inpatient respite care
- Home health aide and homemaker services
- Physical therapy
- Occupational therapy
- Speech language pathology
- Medical social services
- Dietary counseling
- Counseling to help beneficiaries and their families deal with grief and loss

Hospice services must be provided by a Medicare-approved hospice and are usually provided in the patient's home. However, inpatient SNF, short-term hospital, and inpatient respite care (care given to a hospice patient so that the usual caregiver can rest) are covered when needed.

Hospice Information

For additional information regarding hospice coverage and services, refer to the *Medicare Hospice Benefits* guide available at *www.medicare.gov/publications/pubs/pdf/02154.pdf* on the Web.

UNDERSTANDING THE MEDICARE PART B BENEFIT

Medicare Part B, referred to as "Medical Insurance," helps cover doctors' services, certain medical items, and outpatient care. Part B also covers medical services such as "therapy services" and some home health care furnished by hospitals, SNFs, and other institutional providers when the beneficiary does not qualify for Part A benefits.

In most cases, a provider can determine if a beneficiary has Part B benefits by looking at the beneficiary's red, white, and blue Medicare Health Insurance card (see Figure 1-1). If the beneficiary's Medicare Health Insurance card says "Medical (Part B)," he or she is entitled to Part B benefits.

The following services and supplies are covered under Part B, when medically necessary:

- Medical services
- Clinical laboratory services
- Some home health care
- Outpatient hospital services
- Blood transfusions (after the first 3 pints)
- Some preventive services
- Some ambulance services (when other transportation would endanger health)

Part B Coverage and Payment Criteria

Institutional providers who submit Part B claims should always refer to their Fiscal Intermediary's (FI's) Local Coverage Determinations (LCDs) [formerly known as Local Medical Review Policies (LMRPs)] and other billing guidance for specific coverage and payment criteria. Refer to Section 4, Local Coverage Determination (LCDs) for detailed information regarding LCDs and LMRPs.

Part B requires payment of a monthly premium that is usually taken out of the beneficiary's Social Security, Railroad Retirement, or Office of Personnel Management Retirement payment. If the beneficiary does not receive one of these payments, Medicare will bill for the premium every 3 months. In addition to the premium, the beneficiary must meet an annual deductible and pay all coinsurance amounts unless he or she has other supplemental insurance.

If a beneficiary is entitled to Medicare Part B, covered services for medical care and other services include the following:

- Doctors' services
- Outpatient medical and surgical services and supplies
- Diagnostic examinations and tests
- Ambulatory surgery center facility fees for approved procedures
- Durable Medical Equipment (DME) such as wheelchairs, hospital beds, oxygen, and walkers
- Second surgical opinions
- Outpatient mental health care
- Outpatient physical, occupational therapy, and speech language pathology

If a beneficiary is entitled to Medicare Part B, the covered services for clinical laboratory services include the following:

- Blood tests
- Urinalysis
- Other tests requested by a provider

If a beneficiary is entitled to Medicare Part B and does not have Part A coverage, the covered services for home health care include the following:

- Intermittent skilled nursing care
- Physical therapy
- Occupational therapy
- Speech language pathology
- Home health aide services
- Medical social services
- Durable Medical Equipment (DME) such as wheelchairs, hospital beds, oxygen, and walkers
- Medical supplies and other services

Part B helps cover hospital services and supplies that a beneficiary receives as an outpatient, such as physical therapy, when under a doctor's care. Part B also covers blood transfusions that a beneficiary may receive as an outpatient or as part of a service covered under Part B.

Therapy Services

Financial limitations on therapy services were implemented on January 1, 2006. Detailed information regarding the therapy caps may be found at *www.cms.hhs.gov/TherapyServices/* on the CMS website.

Medicare Part B also helps to cover:

- Some ambulance services when other transportation would endanger the patient's health
- Artificial eyes
- Artificial limbs that are prosthetic devices, and their replacement parts
- Braces - arm, leg, back, and neck
- Chiropractic services (limited), for manipulation of the spine to correct a subluxation
- Emergency care
- Eyeglasses - one pair of standard frames after each cataract surgery with an intraocular lens
- Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by private insurance that paid as a primary payer to Medicare Part A coverage, in a Medicare-certified facility
- Kidney dialysis
- Medical Nutrition Therapy (MNT) services for individuals who have diabetes or kidney disease (unless currently on dialysis) with a doctor's referral; the MNT services will be covered for 3 years after the kidney transplant

- Medical supplies - items such as ostomy bags, surgical dressings, splints, casts, and some diabetic supplies
- Very limited outpatient prescription drugs (e.g., some oral drugs for cancer)
- Preventive services:
  - Initial Preventive Physical Examination (IPPE) - the "Welcome to Medicare" Physical Exam
  - Cardiovascular screening blood tests
  - Screening mammography
  - Screening Papanicolaou (Pap) tests
  - Pelvic screening examination (includes a clinical breast exam)
  - Colorectal cancer screening
  - Prostate cancer screening
  - Influenza, Pneumococcal, and Hepatitis B vaccinations
  - Bone mass measurements
  - Glaucoma screening
  - Diabetes screening tests, supplies, and Diabetes Self-Management Training (DSMT)
    - Smoking and tobacco use cessation counseling
- Prosthetic devices, including breast prosthesis after mastectomy
- Second surgical opinion by a doctor (in some cases)
- Services of practitioners such as clinical social workers, physician assistants (PAs), and nurse practitioners who provide attending physician services and are not employed by or under contract to a hospice agency
- Telemedicine services in some rural areas
- Therapeutic shoes for individuals with diabetes (in some cases)
- Transplants - heart, lung, kidney, pancreas, intestine, bone marrow, cornea, and liver (under certain conditions and when performed at Medicare-certified facilities)
- X-rays, Magnetic Resonance Imaging (MRI) scans, Computed Tomography (CT) scans, Electrocardiograms (EKGs), and some other diagnostic tests

As of January 1, 2005, Indian Health Services (IHS) can submit claims to Medicare for Part B services such as DME, prosthetics, orthotics, therapeutic shoes, clinical laboratory services, and ambulance services in addition to services paid on the Medicare Physician Fee Schedule. Coverage of these other Part B items and services are for a 5-year period beginning January 1, 2005.

Preventive Services Information

Detailed information regarding new preventive services covered under Medicare as of January 1, 2005, is available on the Preventive Services Educational Resources Web Guide available at *www.cms.hhs.gov/PrevntionGenInfo/* on the CMS website.

WHAT IS NOT COVERED BY MEDICARE

The following general medical services are not covered under Medicare Part A or B:

- Acupuncture
- Ambulance transportation to a doctor's office
- Blood transfusions after the first 3 pints of blood
- Cosmetic surgery except when required for the repair of accidental injury or for the improvement of the functionality of a malformed part of the body.
- Custodial care at a nursing home whenever this is the only kind of care required by the patient

- Emergency inpatient services in foreign countries except for some instances in Canada and Mexico to include:
  - When the patient is traveling within the United States, a medical emergency occurs, and the closest hospital that can provide adequate treatment is in either Canada or Mexico
  - When the patient is traveling through Canada without unreasonable delay by the most direct route between Alaska and another state and a medical emergency occurs and the Canadian hospital is closer than the nearest United States hospital that can treat the emergency
    - The patient lives in the United States and the Canadian or Mexican hospital is closer to the patient's home than the nearest United States hospital that can treat the medical condition, regardless of whether an emergency exists
- Private duty nursing, television, or telephone in a patient's inpatient hospital or Skilled Nursing Facility (SNF) room
- A private room in a hospital or SNF unless it is deemed medically necessary
- Custodial care
- Transportation to receive routine health care
- Workers' Compensation (WC) claims

UNDERSTANDING THE MEDICARE ADVANTAGE PLAN

The Medicare Advantage Plan was originally established by the BBA as the Medicare + Choice Plan. This plan introduced a set of health care options that an organization can provide under contract to Medicare, possibly reducing beneficiaries' out-of-pocket expenses, and offering beneficiaries more health care and contractor choices. Beneficiaries who qualify for Part A and Part B benefits have the option to be covered under a Medicare Advantage Plan if a Medicare Advantage Plan organization is available in their area.

Medicare Advantage

Since MMA was signed into law in 2003, the Medicare Advantage Plan has undergone some significant changes. Effective March 1, 2004, increased payments for services went into effect for Medicare Advantage organizations. Additional information regarding the MMA is available at *www.medicare.gov/medicarereform* on the Web and at *www.cms.hhs.gov/MMAUpdate* on the CMS website. The latest posted Medicare Advantage Plan payment rates are available at *www.cms.hhs.gov/MedicareAdvtgSpecRateStats/* on the CMS website.

To participate in the Medicare Program, a Medicare Advantage Plan organization must have a contract with the Secretary of the Department of Health and Human Services (HHS). The plan must provide the same services that a beneficiary would be eligible to receive from Medicare if he or she were enrolled in Parts A and B. In other words, the beneficiary is still technically in the Medicare Program, but has selected an other than fee-for-service Medicare Contractor (i.e., a Medicare Advantage Plan organization) that is required to provide services that have been accredited to meet CMS standards. The Medicare Quality Improvement Program sets requirements for the Medicare Advantage organizations.

Medicare Advantage Plans may include the following:

- Medicare Managed Care Plan
- Health Maintenance Organization (HMO) with a Point of Service (POS) option
- Provider Sponsored Organization (PSO)
- Preferred Provider Organization (PPO)
- Medical Savings Account (MSA)

- Private fee-for-service plan
- Religious fraternal benefit society plan

The Medicare Advantage Plan places special limitations and requirements on beneficiaries with End Stage Renal Disease (ESRD). Individuals entitled to Medicare because they have ESRD are limited to the Medicare Plan, except in special circumstances. A beneficiary with ESRD cannot join a Medicare Advantage Plan; however, if he or she developed ESRD after having enrolled in a Medicare Advantage Plan, he or she can remain enrolled. He or she may also join a different plan offered by the same company in the same state.

If a beneficiary who has ESRD is enrolled in a Medicare Advantage Plan and the plan stops offering service in the beneficiary's service area, he or she may join another Medicare Advantage Plan if one is available. This regulation applies to anyone whose plan left the Program after December 31, 1998.

If a beneficiary leaves his or her Medicare Advantage Plan for other reasons after developing ESRD, he or she can only choose the traditional Medicare Plan.

Individuals who have had a successful kidney transplant and no longer require regular dialysis are not considered to have ESRD. This means that the beneficiary is eligible to join a Medicare Advantage Plan as long as he or she has met all other eligibility requirements.

PROVIDING SERVICES TO PATIENTS ENROLLED IN MEDICARE ADVANTAGE PLANS

Providers and their billing personnel must be aware that Medicare Advantage Plans do not operate under the same coverage and payment policy for claims processing as Medicare. ***If a beneficiary is a member of a Medicare Advantage Plan, the local Medicare Fiscal Intermediary (FI) cannot process claims for that beneficiary.***

If a provider submits a Medicare claim in error to the local Medicare FI for a beneficiary enrolled in a Medicare Advantage Plan, the FI will deny payment (except dialysis and related services provided in a dialysis facility). The provider will need to resubmit the claim.

Providers and billing personnel must be aware that a Medicare Managed Care Plan is **NOT** responsible for paying Medicare Advantage claims, **EXCEPT** under the following situations:

- The provider is affiliated with the Medicare Advantage Plan.
- The provider furnishes emergency services, urgently needed services, or other covered services not reasonably available through the Medicare Advantage Plan.

FILING CLAIMS WITH A MEDICARE ADVANTAGE PLAN

A provider may be reimbursed when filing a claim to a Medicare Advantage Plan if they are an in-network provider, or an out-of-network provider that furnished services that are identified in the second bullet of Section 1.1.5. However, if the plan denies the claim, the provider has the right to appeal the claim to the plan or to the Centers for Medicare & Medicaid Services (CMS). An out-of-plan provider may also collect the full fee-for-services payment from the beneficiary if the beneficiary did not receive prior authorization to see the out-of-plan provider.

Fast-Track Appeals and Grievance Information for SNF, HHA, or CORF Coverage

For information regarding Medicare Advantage appeals and grievances for a beneficiary whose SNF, HHA, or CORF coverage is about to end is available at *www.cms.hhs.gov/MMCAG/* on the CMS website.

PROVIDERS WHO ARE NOT MEDICARE ADVANTAGE PROVIDERS

BEFORE rendering service, providers who are not affiliated with a Medicare Advantage Plan should emphasize to their patient what their financial liability will be if the patient did not receive prior authorization to see the out-of-plan provider. If the patient chooses to see a provider not affiliated with their Medicare Advantage Plan for health care services, he or she should clearly understand that he or she may be responsible for the full fee-for-services rendered.

WHAT IS MEDICAID?

Title XIX of the Social Security Act is a federal/state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the federal and state governments (including the District of Columbia and the Territories) to assist states in furnishing medical assistance to eligible needy individuals. Medicaid is the largest source of funding for medical and health-related services for America's poorest individuals. Within broad national guidelines established by federal statutes, regulations, and policies, each state:

- Establishes its own eligibility standards
- Determines the type, amount, duration, and scope of services
- Sets the rate of payment for services
- Administers its own program

Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity. Thus, an individual who is eligible for Medicaid in one state may not be eligible in another state, and the services provided by one state may differ considerably in amount, duration, or scope from services provided in a similar or neighboring state. In addition, Medicaid eligibility and/or services within a state can change during the year.

THE MEDICARE-MEDICAID RELATIONSHIP

Medicare beneficiaries who have low incomes and limited resources may also receive help from the Medicaid Program. For individuals who are eligible for full Medicaid coverage, the Medicare health care coverage is supplemented by services that are available under their state's Medicaid Program, according to eligibility category. These additional services may include nursing facility care beyond the 100-day limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids. **For individuals enrolled in both programs, any services that are covered by Medicare are paid for by the Medicare Program before any payments are made by the Medicaid Program, since Medicaid is always the "payer of last resort".**

Certain other Medicare beneficiaries may receive help with Medicare premium and cost-sharing payments through their state Medicaid Program. Qualified Medicare Beneficiaries (QMBs) and Specified Low-income Medicare Beneficiaries (SLMBs) are the two best-known and largest categories of these types of beneficiaries. For QMBs, Medicaid pays the Medicare Part A and Medicare Part B premiums and the Medicare deductibles and coinsurance amounts subject to limits that states may impose on payment rates. For SLMBs, the Medicaid Program pays only the Medicare Part B premiums.

A third category of Medicare beneficiaries who may receive help consists of disabled-and-working individuals. According to Medicare law, disabled-and-working individuals who previously qualified for Medicare because of disability, but who lost entitlement because of their return to work (despite the disability), are allowed to purchase Medicare Part A and Medicare Part B coverage. If these individuals meet certain requirements, they may qualify to have Medicaid pay their Medicare Part A premiums as Qualified Disabled and Working Individuals (QDWIs). According to CMS estimates, Medicaid currently provides some level of supplemental health coverage for 5 million Medicare beneficiaries within the above three categories.

States vary in their participation in these programs. Some programs also pay Medicare deductibles and coinsurance amounts.

Availability of "Medicare Savings" Programs

Providers may recommend that low-income patients call 1-800-MEDICARE (1-800-633-4227) to see if such "Medicare Savings" Programs are available locally. TTY/TDD users should call 1-877-486-2048.

HOW IS MEDICARE ADMINISTERED?

As a federal health insurance benefit program, Medicare represents the cooperative efforts and organization of numerous government and non-governmental organizations. The following section identifies the major organizations that work with Medicare.

CONGRESS

Congress passes laws that affect Medicare payments to providers and beneficiaries.

SOCIAL SECURITY ADMINISTRATION (SSA)

The SSA, a federal agency, has special responsibilities in five major benefit areas: retirement; disability; family benefits; survivors; and Medicare. SSA assures that beneficiaries are eligible for Medicare benefits and enrolls them in Part A and/or Part B, the federal Black Lung Program, or a Medicare Advantage Plan. When a beneficiary enrolls in Medicare, CMS issues an initial enrollment package and a Medicare Health Insurance card.

The SSA is also responsible for the following:

- Handling requests for replacements of lost or stolen Medicare Health Insurance cards
- Maintaining and establishing beneficiary enrollment
- Maintaining and updating beneficiary information such as a change in address
- Collecting premiums from beneficiaries who receive retirement or disability benefits
- Educating beneficiaries regarding coverage and insurance choices

DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

HHS is the United States government's principal agency for protecting the health of all Americans and providing essential health services, especially for those who are least able to help themselves. HHS includes more than 300 programs, including Medicare.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

CMS administers the Medicare Program and works in partnership with the states to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. CMS is also responsible for the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), quality standards in health care facilities through its survey and certification activity, and clinical laboratory quality standards.

WHAT ARE FISCAL INTERMEDIARIES (FIS) AND CARRIERS?

Medicare's Part A and Part B fee-for-service claims are processed by non-governmental

organizations or agencies that contract to serve as the fiscal agent between providers and suppliers and the federal government. These claims processors are known as *FIs* and *Carriers*. These contractors apply the Medicare coverage rules to determine the appropriateness of claims.

Directory of FIs and Carriers

To view a current directory of FIs and Carriers, please refer to the Intermediary-Carrier Directory at *www.cms.hhs.gov/apps/contacts/incardir.asp* on the CMS website.

Medicare Contracting Reform (MCR) Update

Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) enacted numerous contracting reforms. A key aspect of these reforms is that Medicare will begin integrating Fiscal Intermediaries (FIs) and Carriers into a new single authority, called a Medicare Administrative Contractor (MAC). As of October 1, 2005, new Medicare Contractors are called MACs. Also, from October 2004 through October 2011, all existing FI and Carrier contracts will be transitioned into MAC contracts, using competitive procedures. Providers may access the most current MCR information to determine the impact of these changes at *www.cms.hhs.gov/MedicareContractingReform* on the CMS website.

Medicare FIs process Part A claims for institutional services, including inpatient hospital claims, SNFs, HHAs, and hospice services. FIs also process Part B claims submitted by institutional providers, including hospital outpatient services. Examples of FIs include the Blue Cross Blue Shield Association (BCBSA), which utilizes its plans in various states, and other commercial insurance companies. An FI's responsibilities include the following:

- Determining costs and reimbursement amounts
- Maintaining records
- Establishing controls
- Safeguarding against fraud and abuse or excess use
- Conducting reviews and audits
- Making payments to providers for services
- Assisting both providers and beneficiaries as needed

Medicare Carriers handle Part B claims for services by physicians and medical suppliers. Examples of Carriers are the BCBSA plans in various states and various commercial insurance companies. Carriers' responsibilities include the following:

- Determining charges allowed by Medicare
- Maintaining quality-of-performance records
- Assisting in fraud and abuse investigations
- Assisting physicians, suppliers, and beneficiaries as needed
- Making payments to physicians and suppliers for services that are covered under the Part B benefit

Physicians and suppliers that have claims processed by Carriers are considered Part B providers. Carriers may only process Part B claims. Conversely, Part A providers that have claims processed by FIs are considered institutional providers. This situation sometimes creates confusion since FIs process Medicare claims for both Part A and Part B benefits. When a provider is called an institutional provider, it simply means that the provider has claims processed by an FI. For example, an Outpatient Rehabilitation Facility (ORF), commonly known as a rehabilitation agency, can only submit claims for Part B services. However, once a rehabilitation agency submits a claim to an FI, the rehabilitation agency is considered an institutional provider. Institutional providers can submit claims for services under the Part A benefit, the Part B benefit, or both (see Figure

1-2). Part B providers (physicians and suppliers) can only submit claims for services under the Part B benefit.

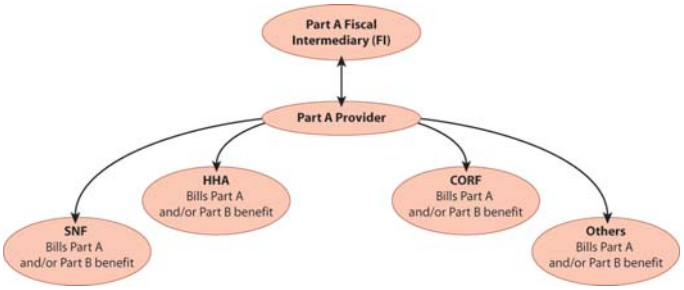


Figure 1-2. Institutional Provider Filing Part A and/or Part B Billing Benefits

WHO ARE MEDICARE BENEFICIARIES?

Medicare Part A eligibility is based on one's earnings, or on the earnings of a spouse, parent, or child. A specified number of "quarters of coverage" (QCs) must be earned through payment of payroll taxes. The exact number of QCs required for insured status depends on the basic group to which the individual belongs. If an individual has paid taxes for 40 QCs, he or she is eligible for "premium-free" Part A. Those who work for shorter periods would pay for premiums based on the length of taxpaying employment.

The three basic types of individuals eligible for Medicare insurance include:

- The aged
- The disabled
- Those with ESRD

Medicare Part B is a voluntary program for which the insured pays a monthly premium. All individuals who are entitled to premium-free Part A are eligible to enroll in Part B. Individuals who are not eligible for premium-free Part A can enroll in Part B if they are all of the following:

- Age 65
- A resident of the United States
- A United States citizen or an alien lawfully admitted for permanent residence who has continuously resided in the United States for the 5-year period immediately preceding the month he or she files for Part B

The cost of this premium is normally automatically deducted from the beneficiaries' Social Security checks and represents 25% of the cost of coverage. The remainder is financed with general tax revenues.

As described earlier, an individual eligible for Medicare (Part A and Part B) has the option to enroll in a Medicare Advantage Plan at any time. Since the enrollee has the option to enroll in Part B or Medicare Advantage at different times than when he or she enrolled in Part A, the effective dates on their Medicare Health Insurance cards may vary, depending on the month/year in which enrollment takes place.

As described in Section 1, "The Medicare-Medicaid Relationship", certain low-income individuals may also qualify through Medicare Savings Programs.

AGED INSURED

An "aged insured" individual is age 65 or older and eligible for monthly Social Security or Railroad Retirement cash benefits, or equivalent federal benefits. Medicare enrollment typically occurs simultaneously upon application for Social Security benefits. Therefore, individuals that receive SSA benefits "early" will be automatically enrolled in Medicare Part A the month they turn age 65.

Medicare Part B is voluntary and becomes effective based on the enrollment period in which the individual enrolls. The earliest an individual may enroll in Part B is between 3 months before and 3 months after he or she turns age 65. If a beneficiary chooses *not* to enroll in Medicare Part B during the initial enrollment period, he or she may enroll at other specified times. However, the cost of Part B may go up 10% for each 12-month period the beneficiary was eligible for Part B and

did not enroll, except in special cases pertaining to the Special Enrollment Period (SEP). The beneficiary will have to pay this extra amount for the rest of his or her life.

Medicare Eligibility Tool

Information about and resources for enrolling in Medicare and a tool to help an individual determine eligibility for enrollment are available at *www.medicare.gov/MedicareEligibility/home.asp?version=default&browser=IE%7C6%7CWinXP&language=English* on the Web.

Medicare Eligibility and Enrollment Information

Questions about Medicare eligibility and enrollment should be referred to the beneficiary' s local Social Security Field Office or the SSA at 1-800-772-1213. TTY users should call 1-800-325-0778.

DISABLED INSURED

An insured individual entitled to Social Security, Railroad Retirement, or equivalent federal benefits based on disability, is automatically entitled to Part A hospital insurance and is considered enrolled for Part B unless coverage was refused by Medicare because the individual does not meet the guidelines provided earlier in this section of the guide. This type of entitlement is also available to a disabled widow or widower or the disabled child of a deceased, disabled, or retired worker. Generally, entitlement begins after the individual has been entitled to receive benefits for 24 months, not the date he or she became disabled. However, individuals whose disability is Amyotrophic Lateral Sclerosis (ALS) do not have to wait 24 months for Medicare. These beneficiaries are entitled to Medicare the first month they are entitled to disability benefits.

If it is determined that an individual is no longer disabled by the Social Security Administration (SSA), a notification of disability termination is sent, and Medicare Part A and Part B entitlement ends the following month.

Special Enrollment Period (SEP)

The SEP is for individuals who did not enroll in premium Medicare Part A during the initial enrollment period because they or their spouse currently worked and had Group Health Plan (GHP) coverage through their current employer or union. An individual can sign up for premium Medicare Part A at any time he or she is covered under the GHP based on current employment. If the employment or GHP coverage ends, the individual has 8 months to enroll in Medicare Part A starting the month after employment or GHP coverage ends, whichever comes first.

END STAGE RENAL DISEASE (ESRD) INSURED

Individuals of any age who require regular dialysis or a kidney transplant are eligible for Medicare if they:

- Worked the required amount of time under Social Security, the Railroad Retirement Board (RRB), or as a federal, state, or local government employee
- Are receiving, or are eligible to receive, Social Security or Railroad Retirement benefits
- Are the spouses or dependent children of such insured or entitled individuals

Entitlement to Medicare usually begins after a 3-month waiting period (e.g., the first day of the third month after the course of renal dialysis begins). Entitlement can begin at an earlier date if certain requirements are met. For example, Medicare coverage can start the month the beneficiary is admitted to a Medicare-approved hospital for a kidney transplant, or for health care services that are needed before the transplant if the transplant takes place in the same month or

within the following 2 months. Medicare coverage can start 2 months before the month of the transplant if the transplant is delayed more than 2 months after the beneficiary is admitted to the hospital for that transplant or for health care services that are needed before the transplant.

Medicare is the secondary payer for claims during the 30-month coordination period for ESRD beneficiaries who are covered by a Group Health Plan (GHP). This 30-month coordination period begins with the first day of Medicare eligibility. The exception is an aged or disabled beneficiary who had GHP coverage that was secondary to Medicare when ESRD occurred.

For patients eligible for Medicare solely based on ESRD, coverage ends on the earliest of the following dates:

- The patient's date of death
- The last day of the 12th month after the month in which the course of dialysis is discontinued, unless the patient receives a kidney transplant during that period or begins another course of dialysis
- The last day of the 36th month after an individual receives a kidney transplant:
  - If the transplant fails and a regular course of dialysis is initiated or another transplant is performed within the 36 months, entitlement continues
  - If a patient whose entitlement is based on ESRD has ended, and he/she begins a new course of dialysis or has a kidney transplant, re-entitlement begins without a waiting period

WHAT ARE MEDICARE BENEFICIARY RIGHTS?

Provider staff should be familiar with the Medicare beneficiary rights that apply to the type of service(s) furnished and the type of Medicare insurance plan for which claims are being submitted. The Medicare beneficiary handbook, *Medicare & You*, is published by CMS and sent to all Medicare beneficiaries. The handbook discusses the guaranteed rights of Medicare beneficiaries, which include the following:

- Protection when the beneficiary receives health care services
- Assured access to needed health care services
- Protection against unethical practices
- The right to receive emergency care without prior approval
- The right to appeal the Medicare Plan's decision about payment/services provided
- The right to information about all treatment options
- The right to know how their Medicare health plan pays its doctors
- The right to submit a written request to a physician or supplier for an itemized statement for any Medicare item or service received [the physician or supplier must furnish the itemized statement within 30 days of the request; failure to provide the statement on time can result in a Civil Monetary Penalty (CMP) of up to $100 for each failure]

Beneficiary Rights Information

CMS has also developed an additional publication, *Your Medicare Rights and Protections*, which provides details about beneficiary rights that are specific to the Original Medicare Plan, Medicare Managed Care Plans, and Medicare Private Fee-for-Service Plans. This document is available at *www.medicare.gov/Publications/Pubs/pdf/10112.pdf* on the Web.

HOW DOES A PROVIDER IDENTIFY AN ELIGIBLE MEDICARE BENEFICIARY?

When an individual becomes entitled to Medicare, he or she receives a Medicare Health

Insurance card. This card contains the following important information that must be included on all claims submitted by providers:

- Name
- Sex
- Health Insurance Claim Number (HICN)
- Effective date of entitlement to Part A insurance
- Effective date of entitlement to Part B insurance

Most Medicare beneficiaries receive Medicare Health Insurance cards issued by the Centers for Medicare & Medicaid Services (CMS) that includes a Medicare number issued by the Social Security Administration (SSA); however, the Railroad Retirement Board (RRB) issues a Medicare Health Insurance card to individuals eligible for Medicare Railroad Retirement benefits. CMS is also the agency in charge of the Medicare Program. The RRB, however, enrolls railroad retirement beneficiaries in the program, deducts Medicare medical insurance premiums from monthly benefit payments, and assists in certain other ways.

SOCIAL SECURITY ADMINISTRATION (SSA)-ISSUED MEDICARE NUMBERS

Medicare numbers issued by the SSA typically reflect the Social Security Number (SSN) of either the insured or a spouse (divorced from the beneficiary or deceased), depending on whose earnings the eligibility is based.

RAILROAD RETIREMENT BOARD (RRB)-ISSUED MEDICARE NUMBERS

Medicare numbers issued by the RRB may contain the insured's SSN or a 6-digit number (zeros may be added at the beginning to bring it to 9 digits). Regardless of the length of the number, the insured's number will always have an alpha *prefix* (with one or more characters). For example, A000-000 or A000-000-000 would indicate a railroad pensioner (by age or disability).

VERIFYING BENEFICIARY ELIGIBILITY

Social Security benefits are the basis for eligibility for most Medicare patients. The eligibility source can be determined by asking to see the patient's Medicare Health Insurance card. Maintaining a photocopy of the card in the patient's file may prevent errors. CMS recommends that providers develop a process to regularly verify Medicare insurance information and update patients' records to reflect current information. Providers may submit claims to Medicare without a copy of the patient's Medicare Health Insurance card, but they should confirm that the patient has coverage prior to submitting a claim. Due to an increase in lost and stolen Medicare Health Insurance cards, checking and copying a patient's picture identification is suggested to ensure that the patient is eligible to receive benefits. *If Medicare has paid a claim for services rendered to a non-Medicare-eligible beneficiary, a refund request may be generated.*

WHAT IS MEDIGAP?

A Medigap policy is a health insurance policy sold by private insurance companies to fill "gaps" in Medicare Plan coverage. Medigap policies must follow federal and state laws that protect the beneficiary. The front of the Medigap policy must clearly identify it as "Medicare Supplemental Insurance." In all states except Massachusetts, Minnesota, and Wisconsin (Medigap "waiver" states), a Medigap policy must be one of 12 standardized policies that can easily be compared. Each policy has a different set of benefits. Two of the standardized policies may have a high deductible option. In addition, any standardized policy may be sold as a "Medicare SELECT" policy. Medicare SELECT is a Medigap plan that requires the beneficiary to use a network of providers. All of the standardized Medicare Plans may be offered as Medicare SELECT policies, however not all plans are available in all states. A Medicare SELECT plan

may lower the cost of a Medigap policy through the use of a network of providers. If a beneficiary is enrolled in a Medicare SELECT plan, he or she must use a provider in the network to get full insurance benefits (except in an emergency).

Medicare SELECT policies usually cost less because the beneficiary must use specific hospitals and, in some cases, specific doctors to get full insurance benefits from the policy. In an emergency, patients may use any doctor or hospital. Certain changes to Medigap policies will occur with the implementation of MMA.

Updated MMA Information

Updated information and assistance with selecting the health plan that best meets the needs of a beneficiary may be obtained using the Medicare Personal Plan Finder Help tool available at *www.medicare.gov/Help/mppf.asp* and at *www.medicare.gov/MPPF/include/DataSection/Questions/Welcome.asp* on the Web.

HOW DO THE MEDICARE SECONDARY PAYER (MSP) PROVISIONS AND COORDINATION OF BENEFITS (COB) PROGRAM WORK?

MSP is the term used when Medicare is the second "insurer" responsible for making payment on beneficiary health care claims. All health care providers are required to determine, prior to submitting claims, whether Medicare is the primary or secondary payer. Medicare becomes the secondary payer when other primary insurance exists. The MSP provisions protect Medicare funds and ensure that Medicare does not pay for services reimbursable under private insurance plans or other government programs. Medicare may not pay if payment has been made, or can be reasonably expected to be made, with respect to an item or service that is covered under other health insurance or coverage. For example, if a Medicare beneficiary is covered by a Group Health Plan (GHP) as a result of his or her current employment or the current employment of his or her spouse, charges for medical services must first be submitted to his or her GHP for payment.

MSP PROVISIONS

Until 1980, the Medicare Program was the primary payer for all beneficiaries, except for those who received benefits from Workers' Compensation (WC) and those that received all covered health care services through the Veterans Health Administration (VHA) programs. Beginning in 1980, changes to Medicare laws increased the number of coverage and benefit programs that are primary to Medicare. Examples include when a beneficiary is covered by a Group Health Plan (GHP) through a current employer or a spouse's current employer (and the employer has 20 or more employees or at least one employer is a multi-employer group that employs 20 or more individuals) or when the beneficiary has been in an accident where no-fault or liability insurance is involved.

MEDICARE COORDINATION OF BENEFITS (COB)

The purpose of the COB Program is to identify health care coverage that beneficiaries may have that pays primary to Medicare and coordinate the payment process to prevent erroneous Medicare primary payments. The Medicare COB contract consolidated activities that support the collection, management, and reporting of other insurance coverage that Medicare beneficiaries have. This is one of many initiatives under the Medicare Integrity Program designed to further expand CMS' campaign against Medicare waste, fraud, and abuse. Please see Section 3, "Submitting Medicare Secondary Payer (MSP) Claims" of this guide for more information regarding submission of MSP claims.

ADDITIONAL RESOURCES

In addition to the materials presented in this section, the following resources are available to provider staff and beneficiaries who need information regarding Medicare:

Provider Resources:

- Access information and resources specific to each Medicare fee-for-service provider type to include new program highlights, Medicare Learning Network (MLN) Matters articles, specialized links to federal regulations, Program Transmittals, Frequently Asked Questions, and ListServs at *www.cms.hhs.gov/center/provider.asp* on the CMS website.
- Access provider practice administration information regarding payment/claims, education, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), provider education, Medicare Secondary Payer (MSP), coverage, coding, policies and regulations, enrollment, manuals, provider specialty-specific resources, participation, Health Insurance Portability Act of 1996 (HIPAA), compliance and Medical Review (MR), grants and demonstrations, rural and urban resources, and contacts at *www.cms.hhs.gov/center/provider.asp* on the CMS website.
- Access updated information regarding coverage and payment policy, claims, contacts, and Frequently Asked Questions available at *www.cms.hhs.gov* and *www.cms.hhs.gov/home/medicare.asp* on the CMS website.
- Access helpful provider-friendly MLN Matters articles that relay information about revisions to Medicare claims processing at *www.cms.hhs.gov/MLNMattersArticles* on the CMS website.
- Obtain local policy and claims processing information from the Medicare Coordination of Benefits (COB) Contractor's website at *www.cms.hhs.gov/COBGeneralInformation/03_ContactingtheCOBContractor.asp* on the CMS website, or by calling 1-800-999-1118 (TTY/TDD users should call 1-800-318-8782).

Beneficiary Resources:

Providers should share the following resources of information with beneficiaries.

- Access answers to common Medicare questions by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users may call 1-877-486-2048.
- Access *www.medicare.gov* on the Web to obtain basic Medicare information and resources such as:
  - **Find available Medicare-approved prescription drug plans, and compare prices for prescriptions** - used by beneficiaries to find an available drug card that meets their specific needs, as well as compare prescription prices
  - **Information about the Medicare Prescription Drug, Improvement, and Modernization Act of 2003** - provides access to the most current information regarding the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) that will help beneficiaries to make the best Medicare coverage decisions
  - **Medicare premiums and coinsurance rates for 2006** - provides the latest premiums and coinsurance rates
  - **Search Tools** - provides access to search tools that the beneficiary can use to:
    - Contact specific organizations to answer Medicare-related questions
    - Find prescription drug and other assistance programs
    - Compare nursing homes
    - Find a personal Medicare plan
    - Access publications such as the *Medicare & You* handbook

- Determine Medicare eligibility
- Find a participating physician
- Determine Medicare coverage
- Compare home health services
- Find a participating supplier
- Access helpful contacts
- Compare dialysis facilities
- Access Frequently Asked Questions

- Access to a State Health Insurance Assistance Program (SHIP) where specially trained staff and volunteer counselors provide personal health insurance counseling. Services are free, unbiased, and confidential. Local phone numbers are available by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

NOTES

This section of the guide introduces billers to the general rules for becoming a Medicare Part A institutional provider. Although the clinical decisions of what services a beneficiary may need or receive is the responsibility of treating institutional providers, billing personnel of any provider's office are the principal point of contact between the beneficiary, the treating clinician, and the Medicare Contractor. In this capacity, the provider's billing personnel must be aware of the many rules and regulations that apply to the setting in which the services are rendered. This section of the guide discusses the various types of institutional providers under Medicare and the general rules and processes with which facilities must comply to enroll as a Medicare Part A provider.

Before an institutional provider may submit claims to Medicare, the provider must first be enrolled as a Medicare provider. The process of enrollment, or of updating enrollment status, begins with the completion of an enrollment application. The Medicare Federal Health Care Provider/Supplier Enrollment Application has been designed by the Centers for Medicare & Medicaid Services (CMS) to assist in the administration of the Medicare Program and to ensure that CMS is in compliance with all regulatory requirements. The information collected from the enrollment application is used to ensure that payments made from the Medicare Trust Fund are only paid to qualified health care providers, and that the payment amounts are correct. This information also identifies that a provider is qualified to render health care services and/or furnish supplies to Medicare beneficiaries. To accomplish this, Medicare must know basic identifying and qualifying information about the health care provider that is seeking privileges to submit claims within the Medicare Program.

WHAT ARE THE TYPES OF MEDICARE PROVIDERS?

The Medicare Program recognizes a broad range of health care facilities and individual providers and suppliers who furnish the necessary services and supplies to meet the health care needs of its beneficiaries. As discussed in Section 1, Part A providers are institutions that provide various services that are paid through Part A and/or Part B Medicare benefits.

Part A providers submit claims to FIs or RHHIs. Part A providers include the following:

- Community Mental Health Centers (CMHCs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- End Stage Renal Disease (ESRD) facilities and Renal Dialysis Facilities (RDFs)
- Federally Qualified Health Centers (FQHCs)
- Histocompatibility laboratories
- Home Health Agencies (HHAs) (including hospital sub-units)
- Hospice facilities
- Hospitals [including freestanding facilities

or units of a medical complex such as a Critical Access Hospital (CAH)]

- Indian Health Services (IHS) facilities
- Organ procurement organizations
- Outpatient Rehabilitation Facilities (ORFs) or rehabilitation agencies (including institutional physical therapy, occupational therapy, and speech language pathology services)
- Psychiatric units (of a hospital)
- Rehabilitation units (of a hospital)
- Religious Non-medical Health Care Institutions (RNHCIs) (e.g., Christian Science Centers)
- Rural Health Clinics (RHCs)
- Rural Primary Care Hospitals (RPCHs)
- Skilled Nursing Facilities (SNFs)

Part B physicians and supplier providers, on the other hand, furnish services and supplies that are only paid through the Medicare Part B benefit, and submit claims to Carriers or Durable Medical Equipment Regional Carriers (DMERCs). Part B providers include:

- Physicians
- Nurse practitioners
- Clinical psychologists
- Physical therapists in private practice
- Occupational therapists in private practice
- Ambulance service suppliers
- Independent diagnostic testing facilities
- Suppliers of durable medical equipment, prosthetics, orthotics, or supplies (DMEPOS)
- Other non-physician providers

WHAT INFORMATION DOES A PROVIDER NEED TO ENROLL AS A MEDICARE PROVIDER?

Medicare requires the following information to enroll a provider:

- The type of health care provider enrolling
- What qualifies this provider as a health care-related provider of services and/or supplies
- Where this provider intends to render these services and/or furnish supplies
- Those persons or entities with an ownership interest or managerial control over the provider

THE ROLE OF FISCAL INTERMEDIARIES (FIS) IN PROVIDER ENROLLMENT

FIs are private insurance companies with which CMS contracts to perform provider enrollment and claims processing on behalf of Medicare. Home health and hospice claims are handled by special FIs called Regional Home Health Intermediaries (RHHIs). Other, less common or rural facility types [e.g., Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs)] may have a single national FI or a specialized regional FI (see Table 2-1).

THE ROLE OF STATE AGENCIES IN PROVIDER ENROLLMENT

The state agency is a government agency within a provider's state government system that is responsible for certifying the provider type(s) for which a facility is qualified to submit Medicare claims. State agencies conduct onsite inspections and other quality of care functions for the Medicare and Medicaid Programs and coordinate efforts with FIs in the institutional provider enrollment process.

Locating State Agencies

A list of state agencies may be found at: *www.cms.hhs.gov/SurveyCertificationGenInfo/03_Contact%20Information.asp* on the CMS website.

Detailed information about state operations can be found in the Medicare State Operations Manual at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website. Search for publication #100-07.

ASSIGNMENT OF ONLINE SURVEY CERTIFICATION AND REPORTING (OSCAR) NUMBER

Once an institutional provider satisfies the enrollment requirements set forth by the Fiscal Intermediary (FI) and state agency, the enrollment application is forwarded to a CMS Regional Office that will then assign the provider an OSCAR number. The OSCAR number is a unique 6-digit number that serves as the institutional provider's billing number. Medical complexes offering several different types of facilities (or units) may have multiple OSCAR numbers representing each distinct unit [e.g., acute care hospital unit, Long Term Care Hospital (LTCH) unit, and a Skilled Nursing Facility (SNF) unit].

HOW CAN AN INSTITUTIONAL MEDICARE PROVIDER ENROLL IN MEDICARE PART A OR UPDATE ENROLLMENT STATUS?

Health care institutional providers must enroll in the Medicare Program to be eligible to receive Medicare payment for covered services. This involves the completion of Form CMS-855A that collects payment and other general information about the provider and secures documentation to ensure a provider is qualified and eligible to enroll in the Medicare Program as a Part A provider. The FI assists providers in determining the appropriate facility type(s) that a provider may enroll as and the appropriate forms or form sections that must be completed. After the completed forms are submitted, the FI will verify all submitted information. **It is important that providers respond to the FI as soon as possible if asked for more information during the enrollment process.** Failure to do so will delay enrollment in the Medicare Program.

Providers must simultaneously contact their state agency that handles site surveys to determine if one is required for their provider type(s). Although the CMS Regional Office is ultimately responsible for deciding whether a provider may participate in the Medicare Program, the state agency submits evidence and recommendations for Regional Office determination. **Failure to contact the state agency may delay enrollment into the Medicare Program.** The state agency must also be made aware if a provider is submitting an application for more than one facility type since the survey and certification requirements vary by type of facility. These surveys determine whether a provider meets applicable requirements for participation in the Medicare Program and the state's requirements. The survey also evaluates a provider's performance and effectiveness in rendering safe and acceptable quality of care.

Institutional providers are required to submit the Form CMS-855A when the provider has a change of information within 90 days of the change. When the provider is providing notification of a change of ownership (referred to as a CHOW) or a change in control, notification of the change must be submitted within 30 days of the change. If an institutional provider is enrolled as a Medicare provider but never completed a Form CMS-855A as a Medicare provider, the provider must notify the appropriate FI when any changes occur.

Special Note for Inpatient Facility Billers

Most Part B services furnished by inpatient facilities (e.g., hospitals, SNFs) are billed to FIs; therefore, hospitals must enroll with FIs using Form CMS-855A. However, if an inpatient facility is also submitting claims for some services of physician or practitioner employees, then these claims must be submitted to a Carrier. If this is the case, then the inpatient facility must also enroll as a supplier with a Carrier using Form CMS-855B. See Table 2-1 for examples of when this might be necessary.

WHAT MEDICARE PROVIDER ENROLLMENT FORMS SHOULD BE SUBMITTED?

As mentioned previously, Medicare requires providers to submit specific forms to enroll or update enrollment status. Previously, all Part A and Part B providers completed a lengthy and complex Form CMS-855.

Enrolling or Updating Enrollment Status

Each provider/supplier setting has very specific instructions for enrollment and for changing enrollment status. Detailed information by state can be accessed at *www.cms.hhs.gov/MedicareProviderSupEnroll/* on the CMS website.

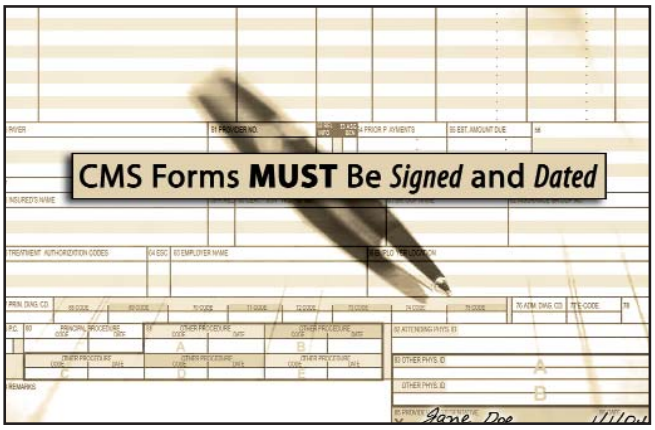
Since the type of information required for enrollment/updates varies by the type of provider, CMS created the following versions of Form CMS-855 that are easier for providers to complete:

- **Form CMS-855A** - Health care providers who will submit claims to Medicare FIs
- **Form CMS-855B** - Health care providers who will submit claims to Medicare Carriers
- **Form CMS-855I** - Individual Health Care Practitioners (e.g., physicians and non-physician clinicians) who will submit claims to Medicare directly
- **Form CMS-855R** - Individual Reassignment of Benefits (e.g., physicians and non-physician practitioners that assign their payments to a group practice)
- **Form CMS-855S** - Suppliers of DMEPOS

The five forms listed above are available for download in Portable Document Format (PDF) at *www.cms.hhs.gov/MedicareProviderSupEnroll/03_EnrollmentApplications.asp* on the CMS website. These versions of the forms can be opened using Adobe Reader, a program available for download at no charge at *www.adobe.com* on the Web. PDF files cannot be used to enter information electronically; to use these forms, print a paper copy and either write or type the required information.

User guides and other software support are also available for the electronic forms. The electronic format will allow providers and suppliers to complete the forms and save information for future use (e.g., if the provider or supplier must report changes). The electronic format will provide real-time edit checks and instructions for completing the form.

These forms cannot be submitted electronically; rather, the forms must be printed and submitted in hardcopy format. **The form must be signed, dated, and mailed to the contractor for the provider's locality.**



Determining Local Contractors

An applicant can determine the current contractor for a particular locality at *www.cms.hhs.gov/MedicareProviderSupEnroll/PSEC/list.asp* on the CMS website.

The following additional forms may be required in addition to the appropriate form to help facilitate institutional provider payments:

- **Form CMS-588** - Medicare Authorization Agreement for Electronic Fund Transfers (EFTs)
- **Form CMS-460** - Medicare Participating Physician or Supplier Agreement
- **Electronic Data Interchange (EDI) Agreement Form** - Medicare authorization for submitting electronic data

If an institutional provider has any questions regarding the proper completion of any of these forms, he or she should contact the appropriate Medicare Contractor for assistance. Table 2-1 summarizes the key contacts and application forms that are required to enroll as a Medicare provider and indicates whether an on-site survey and certification is required for each type of Medicare provider.

CMS Enrollment Forms and Instructions

All of the CMS enrollment forms and user guidance for completing the forms are available at *www.cms.hhs.gov/MedicareProviderSupEnroll/03_EnrollmentApplications.asp* on the CMS website.

Additional Enrollment and Certification Information

Additional enrollment or certification requirements may be necessary. More specific information can be accessed at *www.cms.hhs.gov/MedicareProviderSupEnroll/* on the CMS website.

Table 2-1. Provider Enrollment Contacts and Survey Requirements

Enrollment Form Type	Provider/Supplier Type Affected	Who Should Complete This Form	Contacts
CMS-855A	Community Mental Health Center (CMHC), Comprehensive Outpatient Rehabilitation Facility (CORF), End Stage Renal Disease (ESRD) Facility/Renal Dialysis Facility (RDF), Federally Qualified Health Center (FQHC), Histocompatibility Laboratory, Home Health Agency (HHA), Hospice, Hospitals (All), Indian Health Services (IHS) Facility, Organ Procurement Organization, Outpatient Physical Therapy, Occupational Therapy/Speech Language Pathology Services,	If you are a health care organization and you: ❖ Plan to bill Medicare for Part A medical services provided to Medicare beneficiaries ❖ Are already enrolled in Medicare and need to make changes to your enrollment data. A change must be reported within 90 days of the change.	Fiscal Intermediary (FI) State Agency for Survey and Certification *For RNHIs only, the Boston Regional Office has primary responsibility for the survey and certification process.

Enrollment Form Type	Provider/Supplier Type Affected	Who Should Complete This Form	Contacts
CMS-855A (Con't)	Religious Non-medical Health Care Institution (RNHI)*, Rural Health Clinic (RHC), Skilled Nursing Facility (SNF)		
CMS-855B	Hospital Department(s), Multi-specialty Clinic, Physical/ Occupational Therapy Group in Private Practice, Public Health/ Welfare Agency, Single Specialty Clinic, Ambulance Service Supplier, Ambulatory Surgical Center (ASC), Independent Clinical Laboratory, Independent Diagnostic Testing Facility (IDTF), Mammography Center, Mass Immunization Roster Biller Only, Part B CAP Drug Vendor, Portable X-ray Supplier, Radiation Therapy Center, Slide Preparation Facility, Voluntary Health/Charitable Agency	If you are a group/organization who plans to bill Medicare for Part B medical services provided to Medicare beneficiaries and you are: ❖ A medical practice or clinic that will bill for Medicare Part B practitioner services such as group practices, clinics, independent laboratories, portable X-ray suppliers, physical therapists in private practice, etc. ❖ A hospital or other medical practice or clinic that may bill for Medicare Part A services but that will also bill for Medicare Part B practitioner services or provide purchased laboratory tests to other ❖ Medicare Part B billing entities. ❖ Currently enrolled with a Medicare fee-for-service contractor but need to enroll in another fee-for-service contractor's jurisdiction (e.g., you have opened a practice location in a geographic territory serviced by another Medicare fee-for-service contractor). ❖ Currently enrolled in Medicare and need to make changes to your business (e.g., you have added or changed a practice location). Changes must be reported within 90 days of the effective date of change.	Carrier State Agency for Survey and Certification as applicable

Enrollment Form Type	Provider/Supplier Type Affected	Who Should Complete This Form	Contacts
CMS-855I	Anesthesiology Assistant, Audiologist, Certified Nurse Midwife, Certified Registered Nurse, Anesthetist, Clinical Nurse Specialist, Clinical social worker, Mass Immunization Roster Biller, Nurse Practitioner, Occupational Therapist in Private Practice, Physical Therapist in Private Practice, Physician Assistant, Psychologist, Clinical Psychologist Billing Independently, Registered Dietitian or Nutrition Professional and all Physician Specialties.	If you are an individual practitioner who plans to bill Medicare for Part B medical services provided to Medicare beneficiaries and you are: ❖ An individual practitioner who will provide services in a private setting. ❖ An individual practitioner who will provide services in a group setting. If you plan to render all of your services in a group setting, you will complete Sections 1-4 and skip to Sections 14 through 17. ❖ Currently enrolled with a Medicare fee-for-service contractor but need to enroll in another fee-for-service contractor's jurisdiction (e.g., you have opened a practice location in a geographic territory served by another Medicare fee-for-service contractor). ❖ Currently enrolled in Medicare and need to make changes to your information (e.g., you have added or changed a practice location). ❖ An individual who has formed a professional corporation, professional association or a limited liability company for which you are the sole owner.	Carrier State Agency for Survey and Certification as applicable
CMS-855S	Medical Supply Company, Medical Supply Company with Registered Pharmacist,	If you plan to bill Medicare for Durable Medical Equipment, Prosthetics, Orthotics,and Supplies (DMEPOS) provided to Medicare beneficiaries and you are: ❖ Enrolling in Medicare for the first time as a DMEPOS supplier.	

Enrollment Form Type	Provider/Supplier Type Affected	Who Should Complete This Form	Contacts
CMS-855S (Con't)	Medical Supply Company with Respiratory Therapist, Medical Supply Company with Orthotics Personnel, Medical Supply Company with Prosthetics Personnel, Medical Supply Company with Prosthetic/Orthotic Personnel, Medical Supply Company with Pedorthic Personnel, Orthotics Personnel, Pedorthic Personnel, Prosthetics Personnel, Prosthetic/Orthotic Personnel, Rehabilitation Agency, Optician, Optometrist, Home Health Agency (HHA), Skilled Nursing Facility (SNF), Intermediate Care Nursing Facility, Nursing Facility (other), Pharmacy, Grocery Store, Department Store, Occupational Therapist, Physical Therapist, Physician Therapist, Ambulatory Surgical Center (ASC), Rehabilitation Agency Indian Health Service (IHS), Oxygen Supplier	❖ Currently enrolled in Medicare as a DMEPOS supplier and need to make changes to your business, other than enrolling a new business location (e.g., you are adding, deleting, or changing existing information under this Medicare Supplier Billing Number). Changes must be reported within 30 days of the effective date of change. ❖ Currently enrolled in Medicare as a DMEPOS supplier but need to enroll a new business location. This is to add a new location to an organization with a tax identification number already listed with the NSC. This differs from changing information on an already existing location. ❖ Currently enrolled in Medicare as a DMEPOS supplier and have been asked to verify or update your information. This includes if you have been asked to attest that your organization is still eligible to receive Medicare payments. ❖ Reactivating your Medicare DMEPOS Supplier Billing Number (e.g., your Medicare Supplier Billing Number was deactivated because of non-billing, and you wish to receive payment from Medicare for future claims). ❖ Voluntarily terminating your Medicare DMEPOS Supplier Billing Number.	National Supplier Clearinghouse (NSC) State Agency for Survey and Certification are not applicable

Obtaining Help With Enrollment Issues

A provider can obtain assistance with enrollment issues or questions from the local contractor assigned to the geographic location in which the contractor is located. A complete list of contractors is available at *www.cms.hhs.gov/SurveyCertificationGenInfo/03_Contact%20Information.asp* on the CMS website.

WHAT ARE THE STAGES OF THE ENROLLMENT PROCESS FOR INSTITUTIONAL PROVIDERS?

Medicare has different enrollment processes depending upon the type of provider.

When Part A providers enroll in Medicare, the process generally proceeds as shown in Figure 2-1.

COMMON PROVIDER ENROLLMENT QUESTIONS

Listed below are common questions asked by institutional providers when enrolling in the Medicare Program.

Who is the authorized representative?

The authorized representative must be an officer, Chief Executive Officer (CEO), or general partner of the organization. This individual is a person to whom the enrolling organization has granted the legal authority to:

- Enroll the organization in the Medicare Program
- Make changes and/or updates to the organization's status in the Medicare Program (e.g., adding new practice locations, changing the organization's address, etc.)

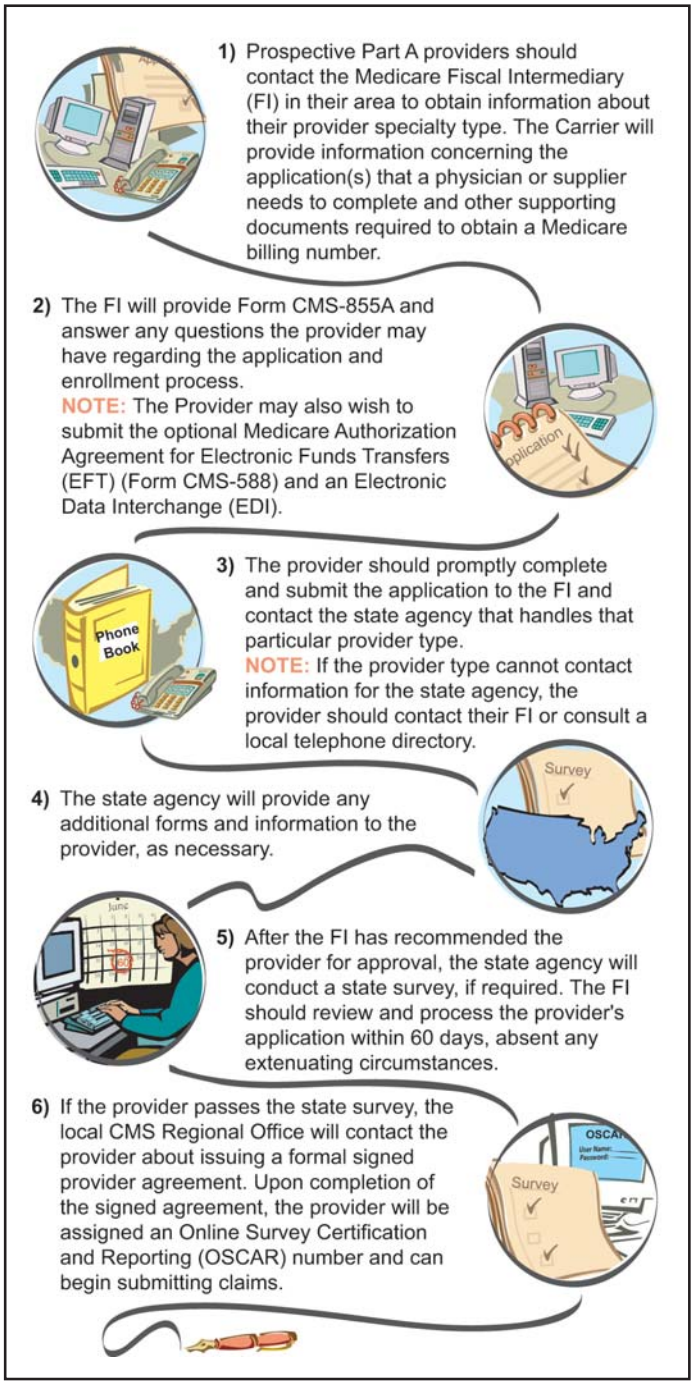


Figure 2-1. Medicare Enrollment Process

- Commit the organization to the laws and regulations of Medicare

What is the effective date of enrollment in Medicare?

This date varies by provider type. The facility should contact the FI for more information.

How long does the enrollment process typically take?

For most applicants, the application process will take 60 days. CMS requires its contractors to process 90% of applications within 60 calendar days of receipt or earlier and process 99% of applications within 120 calendar days of receipt. If the applicant has not submitted all the necessary accompanying documentation or the contractor has to request additional information, the contractor will contact the applicant initially by telephone to expedite the collection of any missing or additional information.

For certain types of providers (e.g., those that require state surveys or accreditation), it will take longer to become enrolled.

How does a provider make changes to the information on file with Form CMS-855?

Changes should be reported within 90 days of the change using the appropriate Form CMS-855, based on the provider type. Providers must complete only the first section of the form and any sections that reflect the changes, additions, or deletions being made and sign the certification statement (see Section 15 of Form CMS-855).

If a facility needs to report changes to enrollment information and have not previously completed a Form CMS-855, the facility can still use the form to make changes to the information. However, a facility must furnish enough information on Form CMS-855 for the FI to make the changes.

Is a photocopy of Form CMS-855 acceptable?

A photocopy of Form CMS-855 is acceptable. However, the signature must be original. Stamped, faxed, or copied signatures are **NOT** acceptable. Although the form may be photocopied **AFTER** it has been signed, it is unlawful to alter it in any manner once it has been signed.

Who needs a surety bond prior to participating in the Medicare Program?

Currently, neither providers nor suppliers are required to obtain surety bonds to participate in the Medicare Program.

What officials in a non-profit organization must be reported on Form CMS-855?

Managing/Directing Employees
Most non-profit organizations are run by a governing board (e.g., Board of Directors). As such, each member of the applicable governing board should be reported in the Managing/Directing Employees section of Form CMS-855.

Owners
Although the vast majority of non-profit organizations do not have owners, any individual who owns at least 5% of the non-profit organization must be reported in the Owner Information section of Form CMS-855.

If a non-profit organization has a unique organizational structure, the organization must contact their FI for more information.

What is a "Participating Provider"?

The term "participating provider" has different meanings for different provider types. For some physicians and suppliers that submit claims to Carriers, the physician or supplier may have flexibility regarding whether to accept Medicare payment as full payment for any or all of their patients. However, certified institutional providers that submit claims to FIs are considered "participating" if the provider is enrolled in Medicare, and therefore must accept Medicare payment policies for all Medicare beneficiaries. By participating in the Medicare Program, the provider agrees to accept assignment for all covered services provided to Medicare beneficiaries. This means that they must accept Medicare payment as payment in full, except for any unmet deductible and coinsurance amount that is the beneficiary's responsibility.

Section 3: Submitting Medicare Claims

After a provider has made the decision to participate in the Medicare Program and has completed the enrollment process, the next decision involves determining how to submit claims for payment. This section of the guide introduces providers to the general rules regarding the claims submission process.

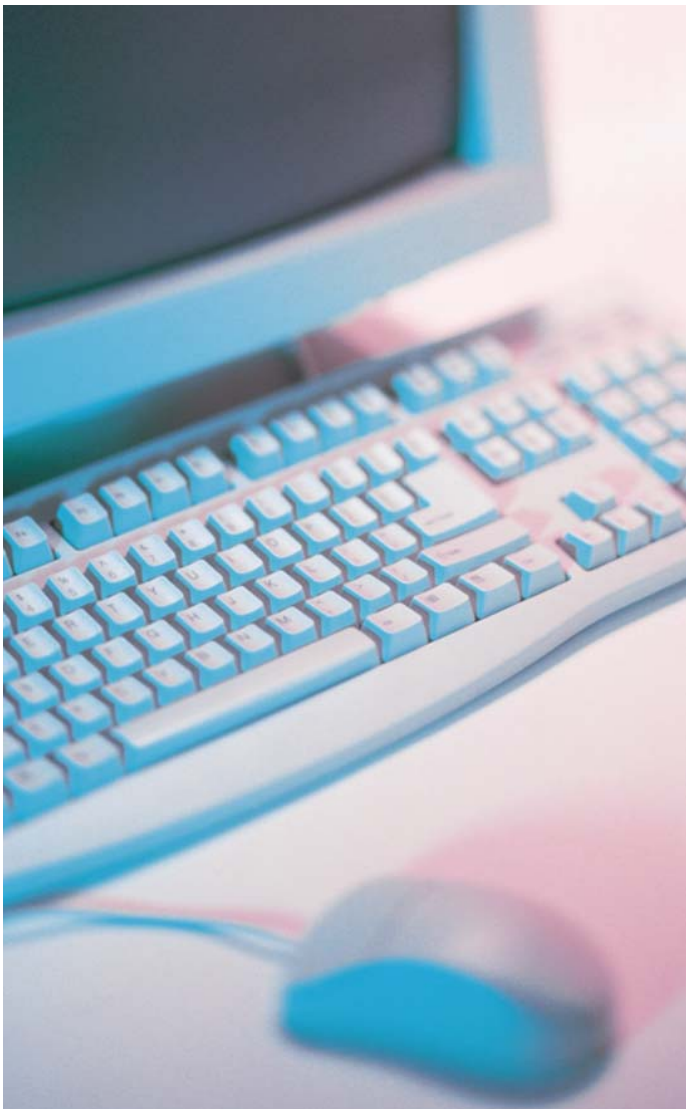
It is helpful for providers to have a thorough understanding of the claims process before submitting claims to Medicare. Providers will need to know when it is appropriate to submit claims electronically or on paper, what claim forms to use, and what, if any, additional documentation to submit. In addition, consideration must be made regarding whether claims should be submitted to Medicare as a primary or secondary insurer, and what documentation is required when the beneficiary is going to lose benefit coverage under Medicare.

Accuracy of Beneficiary Information

*Failure to record the beneficiary's name and identification number on a claim **exactly** as they appear on the Medicare Health Insurance card may result in a claim rejection or payment delay.*

HOW DOES A PROVIDER SUBMIT A PART B CLAIM?

Submission of a claim, whether submitted electronically or on paper, is the only way a provider or beneficiary can receive reimbursement from Medicare. If there are discrepancies on a claim form, the beneficiary may not receive full benefits. Medicare Part B claims are submitted by providers to the Fiscal Intermediary (FI) using Form CMS-1450 (also referred to as the UB-92). See Reference A for a copy of Form CMS-1450 template and instructions for completion.



Form CMS-1450 Claim Form Information

Providers can download an electronic copy of the claim form at *www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp* on the CMS website.

The National Uniform Billing Committee (NUBC) is responsible for the design of the form. Printing specifications for the form are available at *www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp* on the CMS website.

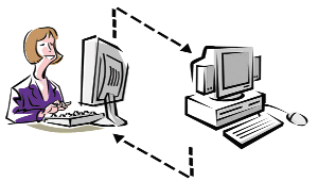
Form CMS-1450s are available for purchase from various vendors such as the Standard Register Company (refer to the local telephone book). The forms are also available in various formats (including negatives) from the United States Government Printing Office (GPO). Contact the GPO at 1-866-512-1800 (or 202-512-1800 in the Washington, DC metropolitan area), or mail publication order inquiries to:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954

Providers can also contact the GPO for printing information at *http://bookstore.gpo.gov* on the Web.

Claims can be submitted in one of the following ways:

- Using Electronic Media Claims (EMCs) submitted from the provider's office or;
- Using a paper claim.



NOTE: A provider may submit EMCs or paper claims directly to a Medicare Contractor or use a third-party billing service who will submit the claims to the Medicare Contractor on the provider's behalf.

***As of October 16, 2003,* providers who are NOT a small provider (institutional organizations with 25 or fewer full-time employees or physicians with 10 or fewer full-time employees) must submit all claims via Electronic Data Interchange (EDI) in the Health Insurance Portability and Accountability Act (HIPAA) format.**

SUBMITTING CLAIMS ELECTRONICALLY

Medicare issues a provider number to a provider who intends to electronically submit Medicare claims. These EMCs are then transmitted from the provider's computer to the Medicare Contractor in accordance with HIPAA electronic filing standards. For additional information regarding HIPAA transaction standards, refer to Section 8, "Introduction to HIPAA".

The EMC submission process eliminates the need for mailroom processing, thereby improving the timeliness of claims. The system also releases claims payments when the timeframe requirements of the Centers for Medicare & Medicaid Services (CMS) are satisfied, resulting in a faster payment turnaround for providers. Generally, correctly filed HIPAA-compliant electronic claims can be paid 14 days after the Medicare Contractor receives the transmission, as opposed to paper claims that process in about 4 weeks. Payment for paper claims must be held for 28 days (see Figure 3-1).

When a provider submits a claim electronically, he or she will receive immediate notification that the Medicare Contractor has received the Medicare claim. Medicare Contractors also have systems that provide notification of critical claim filing errors, allowing providers to correct a claim before it enters the Medicare processing system. This eliminates receiving a denial or having to wait for the claim to be returned for correction. Providers are then able to correct front-end edits immediately and retransmit the claim without waiting a day.

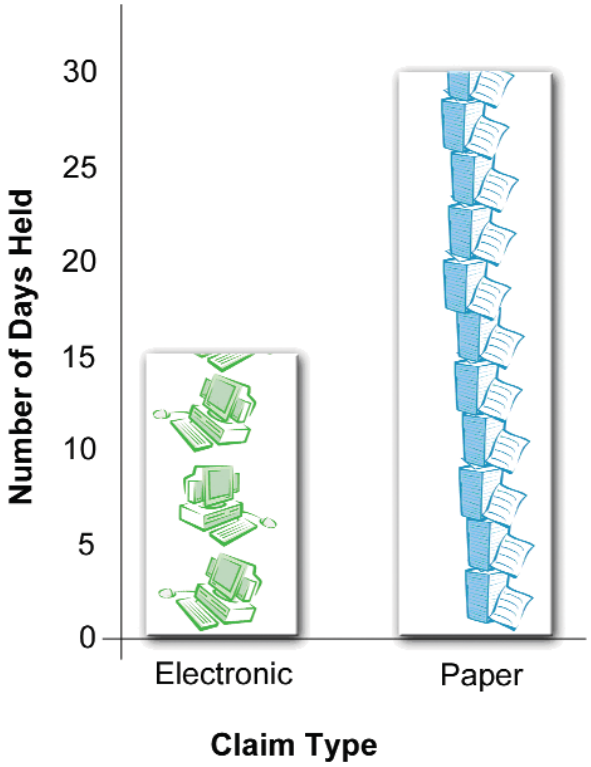


Figure 3-1. Schedule for Electronic and Paper Claims

HOW ELECTRONIC MEDIA CLAIM (EMC) SUBMISSION WORKS

The provider electronically transmits the claim via wire transmission to the Medicare Contractor's (i.e., FI's) computer using the Internet. The FI will use the Fiscal Intermediary Standard System (FISS) to process the claims data and transmit it to another system, where it is electronically checked ("edited") for required information. Claims that pass these initial edits, commonly known as *front-end edits* or *pre-edits*, are then processed according to Medicare policy and guidelines. Claims with inadequate or incorrect information do **NOT** pass the initial edits. Instead, the claims are rejected and are not paid, or the claims are returned to the provider. Rejecting and returning the claim to the provider are two separate functions within the process. If the claim is labeled by FISS as "reject" the claim is rejected. If the claim is labeled by FISS as a "Return To Provider" (RTP), the claim is returned to the provider for correction and resubmission. Refer to Section 6, "Troubleshooting Claim Denials and Claim Rejections", for information that will help troubleshoot an unsuccessful transmission.

After a successful transmission, a confirmation report or acknowledgement report is generated and is either transmitted back to the provider or placed in an electronic mailbox for the provider to download. The provider should immediately and carefully review this report. The report indicates the number of claims accepted and the total dollar amount transmitted. However, this report will also list the claims that were rejected, as well as the reason(s) for being rejected, unless the claim was denied due to medical necessity. If a claim was denied due to medical necessity, the provider cannot correct and resubmit the claim, and instead must appeal the rejection (see Section 7, "Appealing Medicare Claim Denials", for appeals information). Otherwise, the provider can make the necessary correction(s) to the rejected claim(s) and resubmit the corrected claim(s) immediately.

Development Letters/ Record Requests

Occasionally, claims require additional information before they can be processed. An Additional Documentation Request (ADR), also known as a record request, requesting the additional information may be sent to the provider and/or beneficiary. When the information is received, the claim is processed for payment consideration. Failure to respond to a request for additional development may result in denial of a provider's claim.

Development letters may be sent to providers because of Medical Review (MR) activities, or because CMS has requested that a certain percentage of claims be reviewed by the FI for various reasons.

Certificate of Medical Necessity (CMN)

Institutional providers submitting claims to FIs are not required to submit a CMN. CMNs are only required for providers that submit claims to Durable Medical Equipment Regional Carriers (DMERCs) for ambulance, cataract glasses, chiropractor, Durable Medical Equipment (DME), enteral/parenteral nutrition, oxygen, and certain types of podiatry services (see Section 3 of the *Reference Guide for Medicare Physician & Supplier Billers* for detailed information regarding CMNs submitted to DMERCS). However, institutional providers may be asked by suppliers to furnish specific information necessary for the CMN forms that the supplier is required to submit.

For additional information, please refer to Chapter 5, Section 5.3.3, of the *Medicare Program Integrity Manual* at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website. Search for publication #100-08. The local DMERC can also provide additional information regarding completion of CMNs.

The following are alternatives to electronically submitting claims data:

- Providers may work through a software vendor who can provide the level of practice management system support needed for the provider's practice setting
- Providers may submit their Medicare claims directly to the Medicare Contractor or choose to submit claims through a clearinghouse
- Providers may choose to have a billing agent handle all or part of the Medicare claims
- If the provider's office has the required hardware, they may choose to use Medicare's free billing software

Additional Electronic Media Claim (EMC) Benefits

In addition to the day-to-day benefits of EMC, the following features are also available to electronic filers:

- **Eligibility Access:** Participating providers who file claims electronically may acquire access to beneficiary eligibility files through their vendor. The provider can determine if a patient is eligible for Medicare benefits, has met the Medicare deductible, is enrolled in a Health Maintenance Organization (HMO), or is entitled to Medicare when Medicare is the secondary payer.
- **Electronic Remittance Advice (ERA):** A provider can receive notice of paid, adjusted, or denied claims information electronically from FISS. There are many advantages to receiving the ERA electronically including faster communication and payment notification. The ERA may be used to automatically update provider accounts receivable files or the patient billing system.
- **Electronic Claims Status (ECS):** EMC providers may obtain a paper or electronic list of all Medicare pending claims 14 days or older for tracking and monitoring.
- **Electronic Funds Transfer (EFT):** With EFT, FIs can send payments directly to a provider's financial institution whether claims are filed through EMC or on paper.

HOW TO APPLY FOR ELECTRONIC MEDIA CLAIM (EMC) SUBMISSION

To submit an EMC using the Electronic Data Interchange (EDI) in HIPAA format, the Medicare Federal Health Care Provider/Supplier Enrollment Application must be completed prior

to submitting the EMC to Medicare. If providers choose to receive an Electronic Funds Transfer (EFT), they must also complete and submit the Authorization Agreement for EFT.

Once the EDI enrollment form has been accepted by the FI, the provider is integrated into FISS. Using the software supplied by Medicare, the provider must submit a test batch of claims. If the error rate is acceptable to the FI, final approval is granted, and the provider is now ready to submit claims electronically.

An organization comprised of multiple facilities that has been assigned more than one Medicare provider number may elect to execute a single EDI Enrollment Form on behalf of the multiple facilities to which these numbers have been assigned. The organization as a whole would then be responsible for submitting claims for each of its facilities.

Local Fiscal Intermediary (FI) Help Lines

A list of local FI EDI Help Lines is available at *www.cms.hhs.gov/ElectronicBillingEDITrans/03_EDISupport.asp* on the CMS website.

CMS Electronic Data Interchange (EDI) Standard Enrollment Form

Additional information regarding the Medicare Federal Health Care Provider/Supplier Enrollment Application is available in Portable Data Format (PDF) at *www.cms.hhs.gov/ElectronicBillingEDITrans/03_EnrollInEDI.asp* on the CMS website.

An electronic copy of the CMS Electronic Data Interchange (EDI) Agreement Form in PDF is available at *www.cms.hhs.gov/CMSForms/CMSForms/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019477* on the CMS website.

SUBMITTING PAPER CLAIMS

Today, only a limited number of providers are permitted to submit paper claims. **As of October 16, 2003,** providers who do not qualify as small providers (institutional organizations with 25 or less full-time employees or physicians and suppliers with 10 or less full-time employees) must submit all claims via EDI in HIPAA format. Unlike HIPAA-compliant EMC claims that can be paid within 14 days, paper claims cannot be paid until 28 days after the Medicare Contractor has received a "clean" (i.e., error-free) claim.

Providers may never charge Medicare patients for completing or filing a claim. Proper completion and submission of a "clean" (i.e., error-free) Medicare claim is the first step in accurate claims processing. Clean claims are claims that successfully process without system-generated requests for additional or corrected information and contain no data entry errors. Before submitting paper claims, providers should contact their FIs to identify the most effective options for submitting such claims.

NOTE: When submitting a claim to Medicare when Medicare is the secondary payer, the claims must be submitted in hardcopy to the FI. Refer to Section 3, "Submitting Medicare Secondary Payer (MSP) Claims", for guidelines.

Submitting a "Black and White" Form CMS-1450

There are some FIs who will accept "black and white" copies of Form CMS-1450, and copies containing handwritten instead of typed entries. If an FI does accept such a form, the provider may not be required to submit the back side of the form if a signed attestation statement is filed with the FI. This statement should say, "…he or she has read the reverse side of Form CMS-1450 and understands the requirements and agrees to comply with applicable Medicare billing requirements." These options vary by FI.

HOW PAPER CLAIM SUBMISSION WORKS

Some Medicare Contractors process claims using Optical Character Recognition (OCR), an automated scanning process similar to scanners that read price labels in grocery stores. OCR claims processing is faster and more accurate than systems requiring manual input. However, to work properly, OCR must accurately read and interpret the characters entered in each field. OCR software reads only typed or machine-printed data. If an FI uses OCR software for automated claims processing, only an original, red-ink-on-white-paper Form CMS-1450 may be submitted.

After the claims information is scanned, it is transmitted to the claims processing system where it is validated and compared to other data until final processing occurs.

To ensure accurate, quick claim processing, the following guidelines should be followed:

- Do not staple, clip, or tape anything to the Form CMS-1450 claim form.
- Place all necessary documentation in the envelope with the Form CMS-1450 claim form.
- Put the patient's name and Medicare number on each piece of documentation submitted.
- Use dark ink.
- Use only uppercase (CAPITAL) letters.
- Use 10- or 12-pitch (pica) characters and standard dot matrix fonts.
- Do not use italics or script.
- Avoid using old or worn print bands or ribbons.
- Do not use dollar signs, decimals, or punctuation.
- Enter all information on the same horizontal plane within the designated field.
- Do not print, hand-write, or stamp any extraneous data on the form.
- Use only lift-off correction tape to make corrections.
- Ensure data is in the appropriate field and does not overlap into other fields.
- Remove pin-fed edges at side perforations.
- Use only an original red-ink-on-white-paper Form CMS-1450 claim form.

ARE THERE ANY SPECIAL CONSIDERATIONS WHEN SUBMITTING MEDICARE CLAIMS?

Depending on the specialty of the provider, there are additional special considerations a biller must be aware of when submitting claims. These considerations include:

- Determining whether claims should be submitted to Medicare
- Providing Advance Beneficiary Notices (ABNs)
- Providing Notice of Exclusions of Medical Benefits (NEMBs)
- Deciding what additional documentation to submit with the initial claim if the Fiscal Intermediary (FI) requests additional information

SUBMITTING MEDICARE SECONDARY PAYER (MSP) CLAIMS

MSP is the term used when Medicare is not responsible for making the primary payment on beneficiary health care claims. All health care providers are required to determine, prior to submitting claims, whether Medicare is the primary or secondary payer. Medicare becomes the secondary payer when other primary insurance exists. The MSP provisions ensure that Medicare will make primary payment for claims when Medicare has primary payment responsibility for health care services provided to a Medicare beneficiary. However, Title XVIII,

Section 1862(b) of the Social Security Act specifies that, under certain conditions, private insurance companies must make payment for services rendered to a Medicare beneficiary when the beneficiary carries a primary private insurance policy before Medicare will make payment. Recovery actions from other insurers are undertaken when Medicare primary payment errors are identified.

Medicare makes secondary payment for conditions when Medicare beneficiaries:

- Are covered under Group Health Plans (GHPs)
- With End Stage Renal Disease (ESRD) are covered under GHPs
- With ESRD are covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA)
- Have been in an accident involving no fault or liability insurance
- Are covered under Workers' Compensation (WC)
- Are covered under Veterans Health Administration (VHA) benefits
- With black lung disease are covered under the federal Black Lung Program

PROVIDER RESPONSIBILITIES UNDER THE MEDICARE SECONDARY PAYER (MSP) PROVISIONS

Providers should obtain billing information prior to providing services to Medicare beneficiaries. It is recommended that providers request that beneficiaries complete the CMS Secondary Claim Development (SCD) questionnaire or a questionnaire from which billing information can be obtained. Providers should submit any MSP information, including the SCD questionnaire and Explanation of Benefits (EOB), to the FI, including Condition Codes and Occurrence Codes. Example SCD questionnaires can be viewed at *www.cms.hhs.gov/InsurerServices/04_medicaresecclaimdevquest.asp* on the CMS website.

MEDICARE SECONDARY PAYER (MSP) PROVISIONS

Until 1980, the Medicare Program was the primary payer in all situations except those involving Workers' Compensation (WC) benefits and those that received all covered health care services through the Veterans Health Administration (VHA). Since 1980, changes in Medicare law have resulted in Medicare being the secondary payer in other situations. The MSP provisions protect Medicare funds and ensure that Medicare does not pay for services reimbursable under private insurance plans or other government programs. Medicare may not pay if payment has been made, or can be reasonably expected to be made, with respect to an item or service that is covered under other health insurance or coverage.

MEDICARE COORDINATION OF BENEFITS (COB) PROGRAM

The purpose of the COB program is to identify health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent and minimize overpayments of Medicare benefits. Information on eligibility and benefits entitlement is obtained from the Common Working File (CWF). Information received based on information gathering and investigation is stored on the CWF in an MSP auxiliary file and is used to facilitate accurate payment.

The COB program provides many benefits for employers, providers, physicians, suppliers, third-party payers, attorneys, beneficiaries, and federal and state programs. All MSP claim investigations are initiated and researched by the COB Contractor, not by the local Medicare FI or Carrier. This one-step approach minimizes the number of duplicate MSP investigations. It offers a centralized, one-stop customer service approach for all MSP-related inquiries, including those on general MSP information (but not related to specific claims or recoveries that serve to protect the Medicare Trust Fund). The COB Contractor provides customer service to all

callers from any source including, but not limited to, beneficiaries, attorneys, or other beneficiary representatives, employers, insurers, providers, physicians, suppliers, and other health plans.

Various methods and programs are used by the COB Contractor to identify situations in which Medicare beneficiaries have other health insurance that is primary to Medicare. FIs and Carriers will continue to process claims submitted for primary or secondary payment. Claim processing is not a function of the COB Contractor.

Medicare Secondary Payer (MSP) Inquiries

Refer all MSP inquiries to the COB at 1-800-999-1118. TTY/TDD users should call 1-800-318-8782. Contact the local FI regarding claims and/or recovery-related questions.

NOTE: All possible insurers must be identified. There may be situations in which more than one insurer is primary to Medicare [e.g., liability or no-fault insurer, or a Group Health Plan (GHP)].

BENEFITS OF THE MEDICARE SECONDARY PAYER (MSP) PROVISIONS

The successful implementation of the MSP provisions has resulted in positive benefits for Medicare, providers, suppliers, and patients. Benefits include the following:

- **National program savings** - claims are paid by insurers that are primary to Medicare, resulting in a national program savings in excess of $4 billion dollars annually
- **Increased revenue** - a provider or supplier that bills a liability insurer is entitled to pursue full charges. Receiving more favorable reimbursement is to the advantage of the provider or supplier. In many instances, insurance companies that are primary will pay the entire amount billed, rather than only the amount authorized under Medicare
- **Lower out-of-pocket expenses** - multiple insurance coverages often reduces the amount a patient is obligated to pay, which includes satisfying deductible amounts and preserving Medicare coverage limits

WHEN MEDICARE IS CONSIDERED SECONDARY

The MSP provisions make Medicare the secondary payer to insurance plans and programs under certain conditions. Three MSP provisions require Medicare to be the secondary payer related to GHPs. These provisions are working aged, End Stage Renal Disease (ESRD), and disability. Other MSP provisions require Medicare to be a secondary payer relating to disease or accidents as a result of employment or coverage available under Workers' Compensation (WC), liability, or no-fault insurance.

In addition, services authorized under the Veterans Health Administration (VHA), the Federal Black Lung Program, and other government programs such as research grants are primary to Medicare even though they are not specific MSP provisions.

When Medicare is the secondary payer, the other payer pays first, and Medicare pays second. A brief description of situations in which MSP provisions apply as follows:

- **Services Payable under GHP Benefits**

  Working Aged - Medicare benefits are secondary to benefits payable under a GHP for individuals age 65 or over who have GHP coverage as a result of their own current employment status or the current employment status of a spouse of any age. This condition applies when:

  - MSP requires employers of 20 or more employees to offer their "working aged"

employees and their spouses age 65 and over the same GHP offered to other employees

- Medicare is the secondary payer to a GHP when a single employer with 20 or more employees [as determined by the Internal Revenue Service (IRS)] sponsors or contributes to the GHP or when multiple employers sponsor or contribute to the GHP and at least one of them has 20 or more employees

ESRD - Medicare benefits are secondary to benefits payable under a GHP for individuals under age 65 who are eligible for, or entitled to, Medicare based on ESRD. This condition applies when individuals with ESRD who can receive secondary Medicare are beneficiaries also covered by a GHP or are beneficiaries who are covered family members of someone who is covered by a GHP. The Medicare coordination period for ESRD is described in Table 3-1.

Table 3-1. Stages of End Stage Renal Disease (ESRD) Coverage Under a Group Health Plan (GHP)

Stage	Timeframe	What Happens:
Stage 1 Waiting Period for Eligibility	3 months from the first day of dialysis.	If GHP coverage is available, the GHP is primary and there is no Medicare coverage during the waiting period.
Stage 2 Coordination Period	Begins with eligibility/entitlement for Medicare based on ESRD. For eligibility/entitlement beginning prior to March 1, 1996, the coordination period lasts 18 months. For eligibility/entitlement periods beginning on or after March 1, 1996, the coordination period lasts 30 months.	GHP is primary and Medicare is the secondary payer during this coordination period.
Stage 3 Primary Medicare Benefits	After the coordination period and until Stage 4 occurs.	Medicare is primary and GHP is secondary.
Stage 4 End of Medicare Benefits	When patient has ceased dialysis treatments for 12 months. OR 36 months after a successful kidney transplant.	Only GHP coverage is available.

End Stage Renal Disease (ESRD) Information

Medicare entitlement can start earlier in some cases where the beneficiary received a kidney transplant or is taking part in a home dialysis training program and expects to complete the training period within the first 3 months of dialysis. There is a separate coordination period each time a beneficiary becomes eligible for Medicare based on kidney failure. Entitlement can be resumed without a waiting period. For additional information, see the publication entitled *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* available at *www.medicare.gov/publications/pubs/pdf/10128.pdf* on the Web.

If a GHP does not pay the entire charge for items or services furnished to a beneficiary, Medicare will make secondary payments, taking into account:

- The amount the GHP has allowed
- The amount Medicare considers reasonable for those items or services

If the GHP provides no benefits at all for particular medically necessary services (e.g., a kidney transplant), Medicare may pay for those services as primary payer, assuming the services are covered under Medicare.

- **Disabled Beneficiaries Covered Under a Large Group Health Plan (LGHP)** - Medicare benefits are secondary to benefits provided by LGHPs for certain disabled individuals under age 65 who have coverage based on their own current employment status or the current employment status of a family member. This applies when a beneficiary is both eligible for Medicare based on a disability and is covered by an LGHP (or the beneficiary is a family member of someone who is covered by an LGHP).

- **Services Related to Liability or No-Fault Insurance Coverage or Employment Related Disease or Accidents**

  Liability or No-Fault Insurance - Medicare benefits are secondary to payments that have been issued or can reasonably expect to be made promptly for items or services under liability or no-fault insurance. Medicare is secondary to liability or no-fault insurance even if state law or a private contract of insurance stipulates that its benefits are secondary benefits or otherwise limits payments to Medicare beneficiaries.

  Employment Related Disease or Accidents - Medicare is secondary payer to WC plans. Payment under Medicare may not be made for any items or services if payment has been made or can reasonably be expected to be made under a WC law or plan. If services are furnished that are not payable by WC, then Medicare is the primary payer for those services.

- **Other Services Where MSP Provisions Apply**

  Veterans Health Administration (VHA) - The VHA pays for health care services rendered (usually at VHA facilities) to persons who have served in the armed forces. When the VHA is unable to provide services at one of its facilities, the administration may authorize non-federal providers and suppliers to do so at federal expense. When VHA authorized items or services are provided at a non-federal facility, Medicare does not make payment for such items or services. Details about the VHA payment policy are provided within the Medicare Benefit Policy Manual, Chapter 16, Section 50.1, which is available at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website. Search for publication #100-02.

Changes in Medicare Secondary Payer (MSP) Eligibility and Coverage

Eligibility coverage may change during a course of treatment. Providers and suppliers are required to ask Medicare patients periodically if any of these MSP conditions apply.

Table 3-2 lists some common situations when Medicare is the primary and secondary payer.

Table 3-2. List of Common Situations When Medicare May Pay First or Second.

If the patient...	And this condition exist...	Then this program pays first...	And this program pays second...
Is age 65 or older, and is covered by a Group Health Plan (GHP) through a current employer…	The employer has less than 20 employees…	**Medicare**	GHP
	The employer has 20 or more employees or at least one employer is a multi-employer group that employs 20 or more individuals…	GHP	**Medicare**
Has an employer retirement plan and is age 65 or older, or is disabled and age 65 or older…	The patient is entitled to Medicare…	**Medicare**	Retiree coverage
Is disabled and covered by a Large Group Health Plan (LGHP) from work, or is covered by a family member who is working…	The employer has less than 100 employees...	**Medicare**	LGHP
	The employer has 100 or more employees, or at least one employer is a multi-employer group that employs 100 or more individuals…	LGHP	**Medicare**
Has End Stage Renal Disease (ESRD) and GHP Coverage…	Is in the first 30 months of eligibility or entitlement to Medicare…	GHP	**Medicare**
	After 30 months…	**Medicare**	LGHP
Has ESRD and Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage…	Is in the first 30 months of eligibility or entitlement to Medicare...	COBRA	**Medicare**
	After 30 months…	**Medicare**	COBRA

If the patient...	And this condition exist...	Then this program pays first...	And this program pays second...
Is covered under Workers' Compensation (WC) because of a job-related illness or injury…	The patient is entitled to Medicare…	WC (for health care items or services related to job-related illness or injury)	**Medicare**
Has been in an accident where no-fault or liability insurance is involved…	The patient is entitled to Medicare…	No-fault or liability insurance (for accident-related health care services)	**Medicare**
Is age 65 or older OR Is disabled and covered by Medicare and Consolidated Omnibus Budget Act (COBRA)…	The patient is entitled to Medicare…	**Medicare**	COBRA
Has Veterans Health Administration (VHA) benefits…	Receives VHA authorized health care services at a non-VHA facility…	VHA	Medicare may pay when the services provided are Medicare-covered services and are not covered by the VHA

MEDICARE SECONDARY PAYER (MSP) INFORMATION THAT PROVIDERS OR SUPPLIERS MUST OBTAIN FROM A BENEFICIARY OR REPRESENTATIVE

Providers and suppliers are required by law to collect information from beneficiaries regarding the availability of other health insurance related to the items or services included on the claim. In addition, Medicare regulations in 42 CFR 489.20(g) require that providers and suppliers must agree "to bill other primary payers before billing Medicare." Thus, any provider that bills Medicare for items and services must determine whether or not Medicare is the primary payer. This must be accomplished by asking beneficiaries or their representatives questions concerning the beneficiary's MSP status. If providers fail to provide correct and accurate claims with Medicare, regulations permit Medicare to recover its conditional payments to them.

COLLECTING BENEFICIARY MEDICARE SECONDARY PAYER (MSP) INFORMATION

Generally, Medicare policy requires providers to update beneficiary MSP information for every admission, outpatient encounter, or start of care prior to submitting a claim to Medicare. However, there are some exceptions. For additional information regarding those exceptions, refer to Chapter 3, MSP Provider Billing Requirements, of the Medicare Secondary Payer Manual, available at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website. Search for publication #100-05.

SPECIFIC BENEFICIARY MEDICARE SECONDARY PAYER (MSP) INFORMATION THAT MUST BE COLLECTED

There are certain questions that providers should ask of Medicare beneficiaries upon each start of care to help identify other payers that may be primary to Medicare. There are questionnaire tools available that a provider can use to gather insurer information depending on the beneficiary type. For example, the Part A Other Insurer Intake Tool is available at *www.cms.hhs.gov/ProviderServices/04_PartAOtherInsurerIntakeTool.asp* on the CMS website, and the Part B Other Insurer Data Gathering Tool is available at *www.cms.hhs.gov/ProviderServices/05_%20PartBOtherInsurerIntakeTool.asp* on the CMS website.

When COBRA Applies

COBRA is a law that requires employers with 20 or more employees to allow employees and their dependents to keep their group health coverage for a time after they leave their GHP. This is called "continuation coverage" and can last up to 18, 29, or 36 months (in some cases). COBRA and Medicare interact as follows:

- If the beneficiary or spouse are age 65 or over and have COBRA, Medicare is the primary payer.
- If the beneficiary or family member has Medicare based on disability and has COBRA, Medicare is the primary payer.
- If the beneficiary or family member has Medicare based on ESRD, COBRA is the primary payer for a 30-month period and Medicare is the secondary payer.

Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs) for Worker's Compensation (WC) Settlements

Medicare may remain secondary payer even after a WC settlement. If a WC settlement includes compensation for future treatment of medical conditions related to the work-related illness or injury and CMS approved the amounts that were set aside to consider Medicare's interests, then those amounts are referred to as a WCMSA. All WCMSA proposals with the exception of Louisiana and New Jersey must be submitted for CMS Regional Office review at:

CMS
C/O Coordination of Benefits Contractor
P.O. Box 660
New York, NY 10274-0660
Attn: WCMSA Proposal

Once the WCMSA proposal has been recorded in a centralized database, the proposal is forwarded to the Regional Office that has jurisdiction for review of the proposal. Access more detailed information about the process or determine which Regional Office has jurisdiction for review at *www.cms.hhs.gov/WorkersCompAgencyServices/04_wcsetaside.asp* on the CMS website. The two exceptions for review jurisdiction are Louisiana and New Jersey, which are forwarded to the Atlanta Regional Office. In these situations, providers and suppliers would only bill the set-aside account. Once the set-aside account is depleted, Medicare becomes primary. The beneficiary's set-aside balance can be checked by contacting the Carrier or administrator of the WCMSA.

ONLINE VERIFICATION OF MEDICARE SECONDARY PAYER (MSP) INFORMATION

Providers with online capability may now access the following MSP information via the Common Working File (CWF) MSP auxiliary file:

- MSP effective date
- MSP termination date
- Patient relationship
- Subscriber name
- Subscriber policy number
- Insurer type
- Insurer information to include name, group number, address, city, state, and Zip Code
- MSP type
- RA Remark codes
- Employer information to include name, address, city, state, and Zip Code
- Employee data including an ID number

At the provider's discretion, this data may be viewed during either the admission or the billing process. However, the data must be viewed before the claim is submitted to Medicare. If the data are used during admission, the provider can verify the accuracy of each data element using the questions asked during questioning at the start of care.

RETENTION REQUIREMENTS FOR MEDICARE SECONDARY PAYER (MSP) DOCUMENTATION

The provider should retain a copy of the completed admission questionnaires on file or online for audit purposes. Maintaining copies of these documents demonstrates that the provider has conferred with the beneficiary to determine if there is other primary payer coverage. The beneficiary does not need to sign the forms. It is prudent for providers to retain these records for 10 years in a paper, optical image, microfilm/microfiche, or online format.

SUBMITTING A MEDICARE SECONDARY PAYER (MSP) CLAIM

Specific instructions for submitting MSP claims are included in Chapter 3, MSP Provider Billing Requirements, of the Medicare Secondary Payer Manual available at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website. Search for publication #100-05.

WHEN MEDICARE PAYS FIRST IN A MEDICARE SECONDARY PAYER (MSP) SITUATION

Medicare will pay first in an MSP situation called "Conditional Primary Medicare Benefits." There is frequently a long delay between occurrence of an injury and the decision by the state Workers' Compensation (WC) agency in cases where compensability is being contested or is in a comparative liability action. A denial of Medicare benefits pending outcome of the final decision means that beneficiaries might be required to advance their own funds to pay for expenses that are eventually covered by WC, the liability insurer, the no-fault insurer, or Medicare. To avoid imposing a hardship on Medicare beneficiaries pending such a decision, conditional Medicare payments may be made. Such payments are conditional upon reimbursement to the Trust Fund if it is later determined that the services are covered by WC, the no-fault insurer, or the liability insurer. Conditional payments may also be paid for services denied in limited situations.

Conditional primary Medicare benefits may be paid if the beneficiary, provider, physician, or supplier has filed a proper claim with the applicable primary insurer (state WC, liability, and/or no-fault plan) and:

- Payments expected from the applicable plans are not paid promptly (i.e., within 120 days of receipt of the claim at a minimum) for any reason except when the plan claims that its benefits are secondary to Medicare
- The properly submitted claim was denied in whole or in part

- Because of physical or mental incapacity of the beneficiary, a proper claim was not filed with the primary insurer

When such conditional Medicare payments are made, they are made on the condition that both the insurer and beneficiary will reimburse the program to the extent that payment is subsequently made by the insurer.

Medicare Secondary Payer (MSP) Patient and Staff Education

A plain language MSP publication for patient and staff education entitled Medicare and Other Health Benefits: Your Guide to Who Pays First is available at *www.medicare.gov/publications/pubs/pdf/02179.pdf* on the Web.

Additional MSP Information

Additional MSP information can be obtained from the following resources:

- The Medicare Secondary Payer Manual is available at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website. Search for publication #100-05.
- The Medicare COB Contractor by calling 1-800-999-1118 (TTY/TDD users should call 1-800-318-8782)
- The FI or Carrier who can answer questions pertaining to claims-related information
- Frequently Asked Questions (FAQs) available at *questions.cms.hhs.gov/* on the CMS website. Use search term "Coordination of Benefit", "COB", "Medicare Secondary Payer", or "MSP".
- An e-mail address that can be used to submit MSP questions and comments to CMS at *mspcentral@cms.hhs.gov*

WHAT IS A REMITTANCE ADVICE (RA)?

A Remittance Advice (RA) is a notice of payments and adjustments sent to providers, billers, and suppliers. After a claim has been received and processed, a Medicare contractor produces the RA, which may serve as a companion to a claim payment(s) or as an explanation when there is no payment. The RA explains the reimbursement decisions including the reasons for payments and adjustments of processed claims. The RA can take the form of an Electronic Remittance Advice (ERA) or a Standard Paper Remittance (SPR) Advice. The codes listed within the RA help the provider identify any additional actions that may be necessary.

Additional Information on the Remittance Advice (RA)

Detailed information on the RA is contained within the *Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers* document available at *www.cms.hhs.gov/MLNProducts* on the CMS website.

REMITTANCE ADVICE (RA) SUBMISSION FORMATS

Although the RA may be submitted in both the ERA or SPR formats, HIPAA mandates use of the ASC X12 N 835 version 4010A1 format for ERAs. This standard format is also referred to as "the 835." The 835 has required and situational fields. The required fields are mandatory regardless of provider type. The situational fields are used depending on data content and business context and are used if the situation applies. All of the HIPAA-compliant fields and codes apply universally to all entities that transmit health care information. Medicare also requires that RA codes included within the SPR format be the same as required in the ERA format.

CODES USED WITHIN A REMITTANCE ADVICE (RA)

Fields within the 835 are key elements for providing detailed payment adjustment code information relative to a health care claim(s). If applicable, these codes also describe why the total original charges have not been paid in full. Codes within the 835 represent a standardized reason or condition that relates to the service or claim. Although several codes should appear on an RA, all of the applicable code types may not appear at the same time. The codes may be medical or non-medical, and use of a code may vary according to the provider submitting the claim. Refer to Section 8 of this guide for more information regarding HIPAA-compliant code sets.

Two of the most frequently used code sets include the Claim Adjustment Reason Codes (CARCs) and the Remittance Advice Remark Codes (RARCs). CARCs communicate an adjustment, which means that the codes must communicate why a claim or service line was paid differently than as it was submitted. If there is no adjustment to a claim/line, then there is no CARC. Under HIPAA, it is important to understand the term "adjusted." Adjusted indicates that there is a denied payment, zero payment, partial payment, reduced payment, penalty applied, additional payment, or supplemental payment.

RARCs are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a CARC. A RARC may be used at either the claim level or service-line level if it is appropriate for the specific situation. Use of an RARC at the claim level conveys information about claim level adjustments or about the overall processing of the claim. Use of RARCs within the service-line conveys information about adjustments for the specific service-line or about the processing of those services. Since RARCs provide information about remittance processing or further explain an adjustment, RARCs are seldom used unless there is an adjustment to report.

It is important to understand the difference between a CARC and an RARC. CARCs explain an adjustment (an amount paid that is different than the amount submitted on the claim, including a zero payment or a denial) to the amount submitted by the provider. RARCs accomplish two objectives. The CARC and RARC convey informational messages about general remittance practices or they provide a supplemental explanation for an adjustment already described by a CARC.

Finally, it is important to review the CARCs and the RARCs along with other information regarding the 835. These codes help the biller understand the specific business reason for any denial or reduction in payment before making an inquiry to Medicare.

RARC and CARC Information

The most current code list and a description of CARCs and RARCs can be found at *www.wpc-edi.com/codes/codes.asp* on the Web. This code list is updated three times per year.

In addition to the RA, Medicare notifies the beneficiary using a Medicare Summary Notice (MSN). The format of notification that the beneficiary receives may vary depending upon the contractor that processes the claim.

Providers who electronically receive an RA **must be prepared to receive the notice in HIPAA standard format (ASC X12N Transaction 835 version 4010A1), which was required as of October 16, 2003. As of July 1, 2005, providers who receive the RA electronically can no longer receive a paper RA.**

HOW IS A BENEFICIARY NOTIFIED OF DISCONTINUED PROVIDER SERVICES?

Whenever a provider believes that a service or item may not be covered by Medicare as medically reasonable and necessary for one of several denial reasons, such as statutory exclusions that trigger Financial Liability Protections (FLPs), the provider has historically provided the beneficiary with an Advance Benefiary Notice (ABN) of Medicare's likely denial of payment. In all situations where providers discontinue or deny Medicare services, the beneficiary has a right to receive written notification as to the reason the services will no longer be furnished or expected to be paid for by Medicare.

If the provider does not provide the patient with an ABN, the patient cannot be held financially liable for the service/item if Medicare denies payment. Beneficiaries must be notified that payment might be denied or reduced before a service is rendered. The beneficiary may then decide whether he or she wants and is willing to pay for the service. If the provider properly notifies the patient in advance that payment for the service may be denied or reduced, the provider is not held financially liable for the services and may seek payment from the patient if Medicare denies payment.

Effective October 1, 2005, all Home Health Agencies (HHAs), Skilled Nursing Facilities (SNFs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), and hospice facilities must notify beneficiaries covered under Medicare of their right to an expedited review process when these providers anticipate that their coverage will end. Providers must provide notification using one or both of the following new expedited review notices to notify beneficiaries of discontinuation of coverage:

- **Form CMS-10095A**: An Office of Management and Budget (OMB)-approved generic notice

Beneficiary Notice Initiative (BNI) and Advance Beneficiary Notice (ABN) Forms and Information

Information about the BNI and all of the current ABN forms and form instructions can be accessed at *www.cms.hhs.gov/BNI* on the CMS website.

Financial Liability Protections (FLPs)

FLPs apply solely to denials of Medicare payment on the basis of one of the statutory exclusions that, by law, trigger FLPs. The following is a list of exclusions that trigger FLPs and require the provider to send an ABN to the beneficiary:

- **Section 1862(a)(1)** - "medical necessity" exclusion denials per Limitation on Liability (LOL) Section 1879(a)-(g) and per Refund Requirement (RR) Section 1842(l) and Section 1834(j)(4)
- **Section 1862(a)(9)** - "custodial care" exclusion denials - per LOL Section 1879(a)-(g)
- **Section 1814(a)(2)(C) and Section 1835(a)(2)(A)** - homebound and intermittent home health care denials - per LOL Section 1879(g)(1)
- **Section 1861(dd)(3)(A)** - denials because the beneficiary in hospice is found not to be terminally ill - per LOL Section 1879(g)(2)

FLP and Appeal Right Protections Under the BN

Information regarding FLP notices is available within Chapter 30 of the Medicare Claims Processing Manual available at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website. Search for publication #100-04.

- **Form CMS-10095B**: An OMB-approved detailed notice

  Providers and suppliers may use either the two notices listed above, or one of the following standardized ABN notices that have been in use by CMS:

- **Form CMS-R-131-G**: General Advance Beneficiary Notice
- **Form CMS-R-131-L**: Advance Beneficiary Notice to be used for laboratory tests
- **Form CMS-R-296**: Home Health Advance Beneficiary Notice (HHABN)
- **Form CMS-10055**: Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)
- **Form CMS-R-193**: Important Message from Medicare (IM)
- **Letter 1** - Model Hospital-Issued Notice of Noncoverage/HINN - Admission or Preadmission

SPECIFIC CRITERIA FOR THE ADVANCE BENEFICIARY NOTICE (ABN)

An acceptable ABN for the denial or reduction of payment must meet the following criteria:

- The notice must be given in writing and in advance of providing the service/item (where a standard form is mandatory, notice must be given using the standard form).
- The notice must include the patient's name, description of service/item, and reason(s) the service/item may not be paid for by Medicare.
- The patient or authorized representative must sign and date the ABN before a service is rendered, indicating that the patient assumes financial liability for the service/item if payment is denied or reduced for the reasons indicated on the ABN.
- The original ABN should be filed with the patient's medical records. Providers are also encouraged to provide the beneficiary with a copy of the signed notice.

ADVANCE BENEFICIARY NOTICE (ABN) FOR SERVICES PROVIDED PER REFERRAL OR ORDER OF ANOTHER PHYSICIAN

Providers must be aware of the coverage requirements for the services they provide (if they have been made available) to a patient based on a referral or order of a physician. In most cases, the availability of the coverage requirements indicates that the provider knew, or should have known, that payment for the item/service might be denied or reduced.

For services ordered by another physician (e.g., diagnostic tests), the provider furnishing the service is in the best position to determine the likelihood of denial or reduction of payment and, therefore, should provide a proper ABN to the patient. The physician who ordered the services may provide the ABN, but is not required to do so. The provider who actually furnishes the service is responsible for beneficiary notification and can be held financially liable for the service if payment is denied or reduced. Also, the provider furnishing the services may be required to produce a copy of the ABN. In addition, if the ABN is considered unacceptable, the provider furnishing the services will be financially liable for those services.

PROVIDING A NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB) - FORM CMS-20007

The general use Form CMS-20007 NEMB may be used in any case to advise beneficiaries that Medicare will not pay for particular items or services that are not Medicare benefits, before the items are furnished. NEMBs allow beneficiaries to make informed consumer decisions about receiving items or services for which they must pay out-of-pocket and to be

more active participants in their own health care treatment decisions. Whenever it is inappropriate to use an ABN, providers may voluntarily use an NEMB to advise their Medicare patients of the services that Medicare never covers.

CMS has also developed customized NEMBs for the following provider types:

- **Form CMS-10111**: Notice of Exclusions from Medicare Benefits - Home Health Agency (NEMB-HHA)
- **Form CMS-20014**: Notice of Exclusions from Medicare Benefits - Skilled Nursing Facility (NEMB-SNF)

CMS General Use and Notice of Exclusions from Medicare Benefits (NEMB) Forms

General use and draft NEMB forms are accessible at *www.cms.hhs.gov/BNI/* on the CMS website.

Providers may use notices of their own design rather than the general use or a customized NEMB form. Some professional associations, with the assistance and approval of CMS, have developed service-specific NEMB-type notices to advise Medicare beneficiaries of the limits of Medicare coverage for certain items and services. These service-specific notices are not government notices; they are considered proprietary notices of the authoring associations.

NOTES

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Section 4: Introduction to the Medical Review (MR) Process

All Medicare Contractors are required to ensure that payment is made only for those services that comply with Medicare coverage and coding rules. Services must also be reasonable and necessary. For medically necessary services, the contractor is also responsible for ensuring that services are rendered in the most cost-effective manner (i.e., consideration is given to the location of service and the complexity and level of care provided).

For Medicare to ensure that payment is made only for reasonable and necessary services, each Medicare Contractor is required to perform data analysis to identify potentially aberrant patterns of care and to use the MR process.

CMS contracts with Carriers, Fiscal Intermediaries (FIs), and Program Safeguard Contractors (PSCs) to perform the following MR functions: analyzing data; writing local MR policy in the form of Local Coverage Determination (LCDs); and reviewing claims. The entities that perform MR functions are referred to as Medicare "Contractors"; however, not all Medicare Contractors perform all of the MR functions mentioned above.

The contractor requirements listed in the Medicare Program Integrity Manual apply only to contractors who have responsibility for those particular functions. This document is available at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website. Search for publication #100-08. For example, if a contractor has a contract with CMS to only perform data analysis for all Durable Medical Equipment (DME), that contractor would not be required to comply with the LCD requirements or any requirements other than data analysis.

Program Safeguard Contractor (PSC) Functions

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA), which created the authority for CMS to contract with entities other than Medicare Carriers and Fiscal Intermediaries (FIs) to perform certain program safeguard activities. As a result, CMS created Program Safeguard Contractors (PSCs). PSCs take on some, all, or any sub-set of the work associated with the following program safeguard functions in the Umbrella PSC Statement of Work (SOW):

- Medical Review (MR)
- Cost Report Audit
- Data Analysis
- Provider Education
- Fraud Detection and Prevention

NOTE: See the text box in Section 1, "What Are Fiscal Intermediaries (FIs) and Carriers?", for information regarding the transition of FIs and Carriers to a new entity called Medicare Administrative Contractors (MACs) effective October 2005.

HOW DOES POLICY DEVELOPMENT APPLY TO MEDICAL REVIEW (MR)?

The MR process is conducted in accordance with both national and local policies that are the foundation of the review process. The primary authority for all coverage provisions and subsequent policies is the Social Security Act. Contractors use Medicare policies in the form of regulations, National Coverage Decisions (NCDs), coverage provisions in interpretive manuals, and local coverage determinations (LCDs) to apply the provisions of the Social Security Act.

NATIONAL COVERAGE DECISIONS (NCDS)

NCDs are developed by CMS to describe the circumstances for Medicare coverage for a specific medical service, procedure, or device. NCDs generally outline the conditions under which a service is considered to be covered (or not covered) under Title XVIII, Section 1862(a)(1) of the Social Security Act or its applicable provisions. These policies are typically issued as a CMS program instruction. Once published in a CMS program instruction, an NCD is binding on all Medicare Contractors and providers. NCDs made under Title XVIII, Section 1862(a)(1) of the Social Security Act are also binding on Administrative Law Judges (ALJs) during the claim appeal process. For additional information on ALJ review, please refer to Section 7, "What Is The Second Level of Appeal?".

Within 30 calendar days after an NCD is issued by CMS, contractors will either publish the NCD on their contractor website or link to the NCD posted on the CMS website from their contractor website. In addition, the NCD will be included, as soon as possible, within a provider bulletin.

NCDs should not be confused with coverage provisions in interpretive manuals, which are discussed in the following section.

Current NCD Information

A list of the most current NCDs is available at *www.cms.hhs.gov/mcd/search.asp* on the CMS website.

The Medicare National Coverage Determinations Manual is available at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website. Search for publication #100-03.

COVERAGE PROVISIONS IN INTERPRETIVE MANUALS

Coverage provisions in interpretive manuals are coverage instructions published by CMS that are not considered NCDs. These instructions are used to further define when services may be covered or not covered under Medicare. Once published, the coverage provision in an interpretive manual is binding on all Medicare Contractors and providers.

Within 30 calendar days of the new provision being issued by CMS, contractors will either publish the coverage provision on their contractor website or link to the coverage provision posted on the CMS website from their contractor website. In addition, the coverage provision will be included, as soon as possible, within a provider bulletin.

LOCAL COVERAGE DETERMINATIONS (LCDS)

Section 522 of the Benefits Improvement and Protection Act (BIPA) created the LCD. An LCD is a decision by a Medicare Contractor to cover a particular service on a contractor-wide basis in accordance with Title XVIII, Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the service is reasonable and necessary). The Final Rule establishing LCDs was published on November 11, 2003.

Local Medical Review Policy (LMRP) to LCD Conversion

Effective December 7, 2003, Medicare Contractors began issuing LCDs instead of LMRPs. FIs and Carriers should have retired or converted all existing LMRPs into LCDs by December 2005.

Codes that describe what is covered and what is not covered can be part of an LCD. This includes, for example, lists of Healthcare Common Procedure Coding System (HCPCS) codes that identify to which services an LCD applies, lists of International Classification of Disease, 9th Revision, Clinical Modification (ICD-9-CM) codes for which the service is covered, lists of ICD-9-CM codes for which the service is not considered reasonable and necessary, etc. These coding descriptions are only to be included if they are integral to the discussion of medical necessity. LCDs specify under what clinical circumstances a service is considered to be reasonable and necessary. LCDs serve as administrative and educational tools that assist providers with submitting correct claims for payment.

LCDs are published to provide localized guidance to the public and medical community within their jurisdictions. Contractors develop LCDs by considering medical literature, the advice of local medical societies and medical consultants, public comments, and comments from the provider community. LCDs may be developed individually or collaboratively with other contractors. Contractors ensure that all LCDs are consistent with all statutes, rulings, regulations, and national coverage, payment, and coding policies.

LCDs do not provide guidance that addresses fraud. For example, the following sentence would be inappropriate in an LCD: “If, on postpay review, this FI finds that XYZ procedure was billed to Medicare after the effective date of this LCD, it will consider that billing fraudulent.” This sentence would be more acceptable for an LCD if the word “fraudulent” were replaced with the phrase “not reasonable and necessary”.

Access to LCDs

Copies of Draft and Final versions of LCDs are available within the Medicare Coverage Database located at *www.cms.hhs.gov/mcd/search.asp* on the CMS website.

WHAT ARE THE BENEFITS OF MEDICAL REVIEW (MR) TO MEDICARE PROVIDERS AND SUPPLIERS?

MR initiatives are designed to apply NCDs, to define Medicare coverage of medical care through the development of medical policies, and to ensure that LCDs, and review guidelines are consistent with accepted medical practice standards.

The MR process provides the following benefits:

- **Reduced claims payment error rate** - The MR Program identifies and addresses billing errors concerning coverage and coding made by providers, thus reducing the overall claims payment error rate.
- **Decreased denials** - Knowledge of appropriate claims guidelines may result in a reduction in filing errors and an increase in timely payments.
- **Increased educational opportunities** - Medicare provides education on all claims that are denied through MR. Contractors also issue articles and other informational materials. The educational processes provided by Medicare help providers to know what to expect when a claim is submitted to Medicare for payment.

WHAT DOCUMENTATION MAY NEED TO BE SUBMITTED FOR MEDICAL REVIEW (MR)?

To perform effective MR of services rendered by a provider, it may be necessary for the provider to furnish specific documentation upon request by the contractor. The following points about submitting documentation should be kept in mind:

- Every service billed must be documented in the patient's medical record. There must be clear evidence in the patient's record that the service, procedure, or supply was actually performed or supplied.
- The medical necessity for choosing the procedure, service, or medical supply must be substantiated.
- Every service must be coded correctly. Diagnoses must be coded to the highest level of specificity, and procedure codes must be current.
- The documentation must clearly indicate who performed the procedure or supplied the equipment.
- Although it may be dictated and transcribed, legible documentation is required. Existing documentation may not be embellished (e.g., adding what was omitted in the initial documentation); however, additional documentation that supports a claim may be submitted.
- Voluntary disclosure of information by the provider is encouraged. When an error is discovered, any overpayments must be returned to Medicare.

Documentation is requested through the contractor's Additional Documentation Request (ADR) letter. Examples of documentation needed for MR of provider services could include, but are not limited to:

- Medical records including progress notes, a current history and physical, and a treatment plan
- Documentation of the identity and professional status of the clinician
- Laboratory and radiology reports
- A comprehensive problem list
- A current list of prescribed medications
- Progress notes for each visit that demonstrates the patient's response to prescribed treatment
- Documentation supporting the time spent with the patient when using time-based codes
- Any required referrals or prescriptions (for many non-physician services/supplies)
- Any required contractor certifications

WHAT IS THE COMPREHENSIVE ERROR RATE TESTING (CERT) PROGRAM?

The CERT program is designed to measure and improve the quality and accuracy of Medicare claims submission, processing, and payment. The results of these reviews are used to identify and track local, regional, and national error rate patterns. CMS uses this information to address the error rate through appropriate educational and interventional programs.

TYPES OF ERROR RATES

The CERT program calculates the following types of error rates:

- A national paid claims error rate - measures the number of errors made for paid claims on a national basis
- A contractor-specific error rate - measures the number of errors made by a specific contractor [e.g., an FI or Medicare Administrative Contractor (MAC)] during claim processing

- A services processed error rate - measures how well Medicare contractors made appropriate payment decisions on claims
- A provider compliance error rate - measures how well providers prepared claims for submission)

PROVIDER RESPONSIBILITIES FOR RESPONDING TO CERT REQUESTS

Providers have three main responsibilities if they receive a letter from CMS regarding a CERT review request:

- **Maintain and update enrollment information as necessary.** Providers should notify their Medicare Contractor of any change in mailing address, phone numbers, practice location, etc., within 90 days of the change. Keeping address and other contact information current will help ensure that CERT documentation requests are received in a timely fashion and with enough time to complete the request.
- **Provide all requested information.** During a CERT review, providers may be asked to provide more information related to a submitted claim, such as medical records or certificates of medical necessity. This information will assist the CERT review contractor in verifying that the billing was proper. Participation in the CERT program does not violate privacy provisions under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Physicians, providers, and suppliers do not need to obtain additional beneficiary authorization to forward medical records to the designated CERT contractor.
- **Respond to CERT requests promptly.** Providers should respond promptly by submitting the requested supporting documentation within the time frame outlined in the request. If the requested information is not received within 90 days, CERT operations must assume that the services were not rendered.

GUIDELINES FOR SUBMITTING DOCUMENTATION FOR CERT REQUESTS

When responding to a CERT request, follow the directions below for fax or United States Mail submission.

Fax Submission:

1. Send the specific documents listed on the Bar Coded Cover Sheet to support the services of each claim identified on the Medical Records/Documentation Pull List.
2. Place the Bar Coded Cover Sheet in front of the medical records/documentation being submitted for review.
3. Make sure all pages are complete and legible and include both sides of each page, where applicable.

United States Mail Submission:

1. Photocopy each specific records listed on the Bar Coded Cover Sheet to support the services of each claim identified on the Medical Records/Documentation Pull List. Make sure all copies are complete and legible and include both sides of each page, where applicable.
2. Send the specific records listed on the Bar Coded Cover Sheet to support the services of each claim identified on the Medical Records/Documentation Pull List.
3. Place the Bar Coded Cover Sheet in front of the medical records/documentation being submitted for review.

Current CERT Program Information

Providers can learn more about the CERT program by accessing the CERT Program Home Page at *www.cms.hhs.gov/CERT/* on the CMS website.

Additional information can also be found at the CERT Provider Website Home Page, located at *www.certcdc.com/certproviderportal/* on the Web.

WHAT IS PROGRESSIVE CORRECTIVE ACTION (PCA)?

To assist in MR evaluations, CMS designed MR PCA. PCA ensures that MR activity is targeted at identified problem areas and that imposed corrective actions are appropriate for the severity of the infraction of Medicare rules and regulations.

Additional MR Process Information

The Medicare Program Integrity Manual contains additional information regarding the MR process, including how LCDs are developed. The manual may be accessed at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website. Search for publication #100-08.

For Medicare to consider coverage and payment for any item or service, the information submitted by the provider or supplier (e.g., claims and CMNs) must be corroborated by the documentation contained within the patient's medical records, which indicates that Medicare coverage criteria have been met. The patient's medical records include: physician's office records; hospital records; nursing home records; Home Health Agency (HHA) records; records from other health care professionals; and/or test reports. This documentation must be maintained by the physician and/or provider and available to the contractor upon request.

The corroborating information may be requested by CMS and its contractors on a routine basis in instances where diagnoses on the claim or CMN do not clearly indicate medical necessity. For example, documentation to support the medical necessity of therapeutic exercises done by a physical therapist would not be requested in the vast majority of cases where patients have definite medical conditions such as neurological spinal cord injury, Cerebral Palsy (CP), Multiple Sclerosis (MS), or stroke with residual hemiplegia (not all-inclusive). On the other hand, it is more likely that documentation would be requested for patients whose diagnoses are limited to coronary artery disease, congestive heart failure or depression (not all-inclusive).

The contractor MR staff employs a number of procedures to identify claims that do not definitively indicate medical necessity. These techniques include (but are not limited to) data analysis, beneficiary complaints, and alerts from other organizations. If suspected billing problems are identified, then PCA is initiated to ensure that MR activities are targeted at potential problem areas and to ensure that the corrective actions imposed are appropriate for the severity of the problem.

INITIAL STAGES OF PROGRESSIVE CORRECTIVE ACTION (PCA)

The initial stages of PCA consist of the following two steps:

- **Data Analysis** - The decision to conduct MR is driven by data analysis, the first step in PCA for determining atypical billing or billing patterns that might suggest improper billing or payment. Data analysis may consist of general surveillance or it may be in response to specific complaints or reports from various agencies.
- **Probe Reviews** - Before assigning significant resources to examine claims

identified as potential problems, contractors must validate claim errors through the use of probe reviews. Under probe reviews, contractors may examine 20-40 claims per provider for provider-specific problems. Contractors also conduct widespread probe reviews involving approximately 100 claims from multiple providers when a larger problem, such as a spike in billing for a specific procedure, is identified. In either type of review, providers are notified that a probe review is being conducted and are asked to provide medical documentation for the claim(s) in question. Providers are notified of the results of the probe review.

OUTCOMES OF PROGRESSIVE CORRECTIVE ACTION (PCA)

When probe reviews verify that a problem exists, the contractor classifies the severity of the problem as one of the following:

- Minor
- Moderate
- Significant

The classification level of a detected problem is determined according to the:

- Provider-specific error rate (number of claims paid in error)
- Dollar amounts improperly paid
- Past billing history

TYPES OF CORRECTIVE ACTION AVAILABLE WITH PROGRESSIVE CORRECTIVE ACTION (PCA)

There are various types of corrective actions that can be taken in the event a problem is discovered during the PCA process. Actions will be taken according to the severity of the problem, as appropriate. Possible actions that could be taken include:

- **Education** - Problems detected at minor, moderate, or significant levels will require the contractor to inform the provider of appropriate billing procedures.
- **Prepayment review** - Prepayment review consists of MR of a claim prior to payment.
- **Postpayment review** - Postpayment review involves MR of a claim after payment has been made.
- **Consent settlement review** - Involves statistical sampling and analysis of the claim to determine physician overutilization.

PROVIDER EDUCATION

Along with the planned MR activities, provider education developed according to the review findings is an essential part of the PCA process. When individual reviews are conducted, focused provider education is carried out through direct contact between the Medicare Contractor and the provider via telephone, letter, and/or face-to-face contact. The overall goal of providing education is to ensure development of proper billing practices. This will ensure that claims will be submitted and paid correctly because the provider understands what to expect when a claim is submitted to Medicare.

The PCA process also allows contractors to disseminate general provider education that helps all providers avoid repetitive billing errors when submitting claims to the contractor. According to CMS requirements, coverage and payment policy instructions are published and distributed to providers through local Medicare Contractor news bulletins, publications, and websites.

Because the contractor provides educational coverage and payment policy information to practitioners and facilities, providers and their employees are responsible for reading and applying the information. These publications should be kept and used as ongoing references and instructional guides when billing Medicare. In some cases, if the contractor can determine that

the provider knew, or should have known, the proper way to bill or utilize proper coding techniques, the improper billing may be determined to be a willful or fraudulent act.

PREPAYMENT REVIEW

Providers who have been identified as having problems in submitting correct claims may be placed on "prepayment review," a process in which some or all of their claims are subject to MR before payment can be authorized. This type of review may require submission of medical records and includes automated, routine, and complex activities. Prepayment review may affect any provider.

AUTOMATED PREPAYMENT REVIEW

When prepayment review is automated, decisions are made at the system level using available electronic information, without the intervention of contractor personnel. When appropriately implemented, automated review increases decision efficiency and consistency.

Automated review must either:

- Have **clear policy** that serves as the basis for denial
- Be based on *a medically unbelievable service(s)*
- Occur when **no timely response** is received in response to an ADR letter

When a clear policy exists or in the case of *a medically unbelievable service(s)*, contractors may automatically deny the services without stopping the claim for routine or complex review, **even if documentation is attached to the claim.** For example, if 22 units of a time-based, 15-minute HCPCS Code (e.g., 97035-Ultrasound) were billed on a single date for an ankle sprain, it could be denied as *medically unbelievable* that the individual would require 5.5 hours of this procedure.

Reviewers must still make a limitation on a liability determination that may require routine review, based on Title XVIII, Section 1879, of the Social Security Act. If additional documentation has been requested for a claim and the information has not been received within 45 days, the denial can be counted as an automated review if there was no human intervention. If human intervention occurs, the denials are counted as routine review.

NOTE: The term "clear policy" means a statute, regulation, NCD, or coverage provision in an interpretive manual, or LCD that specifies the circumstances under which a service will always be considered non-covered or incorrectly coded. Clear policy that will be used as the basis for frequency denials must contain utilization guidelines that the contractor considers acceptable for coverage.

ROUTINE PREPAYMENT REVIEW

Routine prepayment review requires the intervention of specially trained MR staff. An intervention can occur at any point in the review process. For example, a claim may be suspended for routine review because an MR determination cannot be automated. Routine review requires hands-on review of the claim and/or claims history file and/or internal MR guidelines but does not require the application of clinical judgment by a licensed medical professional.

COMPLEX PREPAYMENT REVIEW

Complex MR involves the application of clinical judgment by a licensed medical professional to evaluate medical records. Medical records include any medical documentation other than what is included on the face of the claim that supports the service that is billed. For DME that require a Certificate of Medical Necessity (CMN), the CMN is considered part of the face of the claim. Complex MR determinations require a licensed medical professional to make a clinical

judgment about whether a service is covered and is reasonable and necessary.

Complex review for the purpose of making coverage determinations must be performed by nurses [Registered Nurse/Licensed Practical Nurse (RN/LPN)] or physicians, unless this task is delegated to other licensed health care professionals. Contractors must ensure that services reviewed by other licensed health care professionals are within their scope of practice and that the professional's specialized expertise is needed in the adjudication of a particular claim type (e.g., speech language pathology claims and physical therapy claims).

PROVIDER-SPECIFIC REVIEW

A provider-specific review may include certain procedures or all claims from a particular provider. This review requires submission of documentation and results in either an educational intervention by the contractor or further corrective actions. Providers are notified that documentation submission is required. If a provider is placed on prepayment review, the procedure codes are contingent upon the scope of the problem identified.

PREPAYMENT EDITS

Prepayment edits are designed by contractor staff and put in place to prevent payment for non-covered and/or incorrectly coded services. These edits are also used to select targeted claims for review prior to payment. MR edit development is the creation of logic (i.e., the edit) that is used during claim processing prior to payment that validates and/or compares data element values on the claim.

SERVICE-SPECIFIC EDITS

Service-specific edits select claims that contain specific services for review. They may compare two or more data element values present on the same claim (e.g., diagnosis code compared to procedure code) or they may compare one or more data element values on a claim with data from the beneficiary's history file (e.g., procedure code compared to history file to determine frequency in the past 12 months).

PROVIDER-SPECIFIC EDITS

Provider-specific edits select claims from specific providers that are flagged for review. These providers are singled out due to unusual practice patterns, knowledge of service area abuses, and/or utilization complaints received from beneficiaries or others. These edits can suspend all claims from a particular provider or place focus on selected services or Place of Service (POS).

NEW PROVIDER/NEW BENEFIT MONITORING EDITS

Contractors must use data analysis to monitor the billing patterns of new providers and to monitor utilization of new statutory benefits to ensure correct coverage and coding from the beginning of the claim submission process. Contractors have the option of performing prepay or postpay review of new providers as needed. Where contractors choose to perform prepay or postpay review of a new provider, the contractors should perform only limited review (i.e., 20-40 claims) to ensure accurate claim submission. The sample size should not impose an administrative burden or significantly impact the provider's cash flow. Use of new benefit edits should be continued until the edits no longer prove effective or until the contractor determines that resources would be best spent on other types of review.

NOTE: While program savings are realized through denials for inappropriate provider billing, optimal results occur when providers no longer submit claims for non-covered or incorrectly coded services.

POSTPAYMENT REVIEW

Postpayment review involves MR of a claim after payment has been made. Postpayment review is generally performed using Statistically Valid

Sampling, which allows an underpayment or overpayment (if one exists) to be estimated without requesting all claims records from providers. This reduces the administrative burden for Medicare and costs for both Medicare and providers. This type of review may require submission of medical records and includes:

- Error validation reviews, also known as "probe" reviews
- Statistical sampling for overpayment estimation reviews
- Consent settlement reviews

See Section 4, "What Documentation May Need To Be Submitted for Medical Review (MR)?", for information regarding what types of medical documentation may be submitted.

CONSENT SETTLEMENT REVIEWS

During a consent settlement review, a statistical sampling and analysis of claims is studied to determine if a provider has overutilized and received an overpayment for billed services. If it is determined and can be documented that a provider has overutilized services based on the sampling of claims studied, the provider is given the opportunity to voluntarily refund the overpayment through a consent settlement. If fraud is suspected or continued non-compliance is demonstrated despite documented educational interventions, a referral may be made to the Benefit Integrity Department or Program Safeguard Contractor (PSC) for investigation and possible suspension.

HOW IS PROGRESSIVE CORRECTIVE ACTION (PCA) SUCCESS MONITORED?

To help assure that PCA successfully educates providers and prevents improper provider billing, Medicare Contractors track interventions (reviews and educational contacts) with individual providers through a Provider Tracking System (PTS).

The PTS will identify all individual providers and track all contacts made as a result of actions to correct identified problems such as eligibility and medical necessity issues. Contractors will then document the name of the individual contacted within the PTS. Contractors use the PTS to coordinate contacts with providers (e.g., MR education contacts). If a provider is contacted as a result of more than one problem, contractors ensure that multiple contacts are necessary, timely, appropriate, and not redundant.

The PTS should contain the date that a provider is put on a provider-specific edit for MR. Contractors will reassess all providers regarding MR on a quarterly basis to determine if their behavior has changed and will note the results of the quarterly assessment in the PTS. If the behavior has been resolved sufficiently and the edit was turned off, contractors will note the date the edit was turned off in the PTS. This process protects providers from unnecessary MR after successfully demonstrating resolution of identified billing problems during PCA.

When a provider appeals an MR determination to the Administrative Law Judge (ALJ), the contractor will share appropriate information in the PTS with the ALJ to demonstrate corrective actions taken so far.

Contractors also track and consider the results of appeals in their MR activities. It is not an efficient use of MR resources and places a burden on providers to deny claims that are routinely appealed and reversed. When such outcomes are identified, contractors will take steps to:

- Understand why Reconsideration Officers, ALJs, or the Medicare Appeals Council (MAC) viewed the case differently than did the review staff
- Discuss appropriate changes in policy, procedure, outreach, or review strategies with the contractor's Regional Office

WHAT PROACTIVE MEASURES CAN BE TAKEN DURING THE MEDICAL REVIEW (MR) PROCESS?

The purpose of MR is to assist the medical community in receiving reimbursement for covered medical care with a minimum of inconvenience and dollar expenditure. The following are some measures that providers can take to help avoid any negative impact associated with the MR process:

- Review and read all contractor publications, including LCDs, and become knowledgeable about the coverage requirements
- Ensure that office staff and billing vendors are familiar with claim filing rules associated with any LCD that affects a provider setting or specialty
- Check records against claims submitted
- Create an educational awareness campaign for Medicare patients that helps them understand any specific coverage limitations or medical necessity requirements for those services provided
- Work with claim submission vendors to incorporate LCD edits
- Perform mock record audits to ensure that documentation reflects the requirements outlined in the LCD

NOTES

NOTES

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191), includes a provision that establishes the "Medicare Integrity Program." The primary goal of Medicare Program Integrity (PI) is to help reduce payment errors and protect and strengthen the Medicare Trust Fund. The Centers for Medicare & Medicaid Services (CMS) staff and Fiscal Intermediaries (FIs) work within a wide range of Medicare Program areas such as cost report auditing, the Medicare Secondary Payment (MSP) provisions, Medical Review (MR), and anti-fraud activities to improve payment accuracy. To meet this goal, contractors must ensure that they pay the right amount for covered services and that services are correctly coded and rendered to eligible beneficiaries by legitimate providers. Providers must make sure they comply with the coverage and payment policies established by Congress and the Medicare Program.

CMS follows four parallel strategies in meeting this goal:

- Preventing fraud through effective enrollment and through education of physicians, providers, suppliers, and beneficiaries
- Early detection (e.g., through MR and data analysis)
- Close coordination with partners, including contractors and law enforcement agencies
- Fair and firm enforcement policies

Most billing errors that providers make are not attempts to knowingly, willfully, or intentionally commit fraud. For example, some errors are the result of provider misunderstanding or a failure to pay adequate attention to Medicare policy. However, other errors are a result of calculated plans to knowingly commit fraud for unjustified payment. When errors are identified, Medicare will take action commensurate with the error made. The agencies responsible for protecting Medicare will evaluate the circumstances surrounding the error and proceed with an appropriate plan of correction.

In rare situations, if a provider has repeatedly submitted claims in error or has demonstrated gross disregard for Medicare conditions of participation, coverage, and payment policy, Medicare will seek legal action against the individual and/or organization. Medicare utilizes cost report auditing, fraud investigation data analysis, and MR to detect potential payment errors. The results of data analysis indicate whether a situation is an error (pursued by the MR unit), potentially fraudulent (pursued by fraud investigators), or neither. Investigations may also be initiated by reports of improper activities reported by individuals, also referred to as "whistle blowers."

The following section describes the application of cost reporting and the basis for cost report auditing with respect to Medicare PI.

WHAT IS COST REPORTING?

Cost reports are prepared by hospitals, Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), and other institutional providers who are or have been paid on a cost reimbursement basis. They provide detailed accounting of costs incurred, provider costs charged to the Medicare Program, and provider cost accounting.

HOW COST REPORTS ARE USED BY AUDITORS

Auditors review either all or part of the cost report and sometimes request additional or supporting documentation to assess whether costs have been properly allocated and charged to the Medicare Program.

HOW ARE PROVIDERS SELECTED FOR COST REPORT AUDITS?

Providers may be selected for cost report audits based on several factors. Selection for an audit does not necessarily indicate a suspicion of wrongdoing. Random cost report audits are sometimes conducted. Some cost report audits are required by law [e.g., End Stage Renal Disease (ESRD) facilities/Renal Dialysis Facilities (RDFs)]. Typically, however, providers are selected for cost report audits on the basis of prior cost report concerns or atypical allocations and costs reported. A provider may also be selected for review by auditors when a specific problem is identified within a particular section of the cost report for which they reported activity (e.g., related party transactions).

WHAT CONSTITUTES AN OVERPAYMENT?

Overpayments are Medicare funds a provider or beneficiary has received in excess of the amount due and payable under the Medicare statutes and regulations. Once it has been determined that an overpayment has been made, the amount of the overpayment is a debt owed to the federal government. Federal law strictly requires CMS to seek recovery of overpayments, regardless of how an overpayment is identified or caused, including when an overpayment mistake is made by CMS.

Medicare strives to ensure payment accuracy; however, mistakes occasionally occur. Providers are responsible for making voluntary refunds to Medicare when overpayments are identified. Additionally, providers are responsible for timely repayment when Medicare notifies them of an overpayment. If a timely repayment is not made after proper notice, interest will accrue on the outstanding balance at an annual rate specified by law. Finally, penalties may be imposed on overpaid monies, depending on the circumstances involved in the case. These overpayments often require the refund of coinsurance payments made by or on behalf of beneficiaries.

Providers who may have questions related to a Medicare overpayment and/or other Medicare debt collection should call the local Medicare Contractor's toll-free customer service number for assistance.

WHAT CONSTITUTES ABUSE?

Abuse describes practices that either directly or indirectly resulted in unnecessary costs to the Medicare Program. Fraud is distinguished from abuse in that, in the case of fraudulent acts, there is clear evidence that the acts were committed knowingly, willfully, and intentionally. Abusive billing practices, on the other hand, may not result from “intent,” or it may be possible to determine that this intent to defraud existed. Although these types of practices may initially be categorized as abusive in nature, under certain circumstances they may develop into fraud if there is evidence that the subject was knowingly and willfully conducting an abusive practice.

EXAMPLES OF ABUSE

The following are examples of abuse from Chapter 10 of the *Medicare Resident & New Physician Guide*, which is available at *www.cms.hhs.gov/MLNProducts* on the CMS website:

- Charging in excess for services or supplies
- Providing medically unnecessary services
- Providing services that do not meet professionally recognized standards
- Billing Medicare based on a higher Fee Schedule than is used for patients not on Medicare
- Submitting bills to Medicare that are the responsibility of other insurers under the MSP provisions
- Violating the participating physician, provider, or supplier agreement with Medicare or Medicaid
- Breaches in the assignment agreement
- Violating the Maximum Allowable Actual Charge Limits or the limitation amount (when applicable)

WHAT CONSTITUTES FRAUD?

Fraud occurs when an individual intentionally deceives or misrepresents the truth, knowing that it could result in some unauthorized benefit to himself or herself or some other individual. The violator may be a physician or other practitioner, a hospital or other institutional provider, a clinical laboratory or other supplier, an employee of any provider, a billing service, a beneficiary, a Medicare Contractor employee, or any individual in a position to file a claim for Medicare benefits.

Fraud schemes range from those perpetrated by individuals acting alone to broad-based activities by institutions or groups of individuals, sometimes employing sophisticated telemarketing and other promotional techniques to lure consumers into serving as the unwitting tools in the schemes. Seldom do perpetrators target only one insurer or the public or private sector exclusively. Rather, most are simultaneously defrauding several private and public sector victims, including Medicare.

EXAMPLES OF FRAUD

Fraud may take such forms as:

- Incorrect reporting of diagnoses or procedures to maximize payments
- Billing for services not furnished and/or supplies not provided; this includes billing Medicare for appointments that the patient failed to keep
- Billing that appears to be a deliberate application for duplicate payment for the same services or supplies, billing both Medicare and the beneficiary for the same service or billing both Medicare and another insurer in an attempt to get paid twice
- Altering claim forms, electronic claim records, medical documentation, etc., to obtain a higher payment amount
- Soliciting, offering, or receiving a kickback, bribe, or rebate (e.g., paying for a referral of patients in exchange for the ordering of diagnostic tests and other services or medical equipment)
- Unbundling or “exploding” charges
- Completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider or supplier
- Billing based on “gang visits” (e.g., a physician visits a nursing home and bills for 20 nursing home visits without furnishing any specific service to individual patients)
- Misrepresentations of dates and descriptions of services furnished or the identity of the beneficiary or the individual who furnished the services
- Billing non-covered or non-chargeable services as covered items

- Using another individual's Medicare Health Insurance card to obtain medical care

Examples of cost report fraud may include:

- Incorrectly apportioning costs on cost reports
- Including costs of non-covered services, supplies, or equipment in allowable costs
- Arrangements by providers or suppliers with employees, independent contractors, suppliers, and others that appear to be designed primarily to overcharge the program through various devices (commissions, fee splitting) to siphon off or conceal illegal profits
- Billing Medicare for costs not incurred, or costs that were attributable to non-program activities, other enterprises, or personal expenses
- Claiming bad debts without first genuinely attempting to collect payment
- Amounts paid to owners or administrators that have been determined to be excessive in prior cost report settlements
- Days of admission or treatment that have been improperly reported and would result in an overpayment if not adjusted
- Program data where provider or supplier program amounts cannot be supported
- Allocation of costs to related organizations that have been determined to be improper

WHAT ARE ADMINISTRATIVE SANCTIONS?

If CMS determines the existence of inappropriate and/or fraudulent behavior on the part of a provider, various administrative sanctions could be taken to address the issue. Possible sanctions that could be taken include:

- Denial or revocation of provider number application
- Suspension of provider payments
- Application of Civil Monetary Penalties (CMPs)

DENIAL OR REVOCATION OF PROVIDER NUMBER APPLICATION

CMS has the authority to deny or revoke an individual or organization application for a Medicare provider number if there is evidence of impropriety (e.g., previous convictions, false information on the application) or if the provider does not meet state/federal licensure or certification requirements.

If changes have occurred to information on original applications for Medicare provider numbers, individual providers or organizations must notify the applicable Medicare Contractor or state agency. Examples of such changes may include an address change, change of ownership, change in the name of the business, or change in the Tax Identification Number (TIN). Failure to notify Medicare of changes may result in revocation of provider billing privileges, thereby preventing payments from Medicare.

Additional Provider Enrollment Information

Additional information regarding the application for provider numbers, adding/deleting group members, or changes to addresses is available at *www.cms.hhs.gov/MedicareProviderSupEnroll/03_EnrollmentApplications.asp* on the CMS website.

SUSPENSION OF PROVIDER PAYMENTS

CMS has the authority to suspend payment to a provider if fraud is suspected or if an overpayment exists. This action may be necessary to protect the Medicare Program against financial loss. Payment suspensions may last up to 180 days and, in certain cases, an additional 180-day payment suspension may be

imposed, or the payment suspension may be imposed for an indefinite period.

Claims submitted by a provider during a payment suspension will continue to be processed, and the provider will continue to be notified of claim determinations. Appeal rights are available for the processed claims. However, Medicare withholds the actual payment(s) for the claims. The withheld payment(s) may be used to offset or recoup overpaid funds identified by Medicare.

There are no appeal rights to the decision to suspend payments. However, providers may submit written rebuttals addressing why a payment suspension should not be imposed. A payment suspension may be lifted once the overpaid funds are recovered or if sufficient information is in the provider's rebuttal statement to demonstrate that the payment suspension is not necessary.

CIVIL MONETARY PENALTIES (CMPS)

Title XI, Section 1128A(a) of the Social Security Act authorizes the imposition of CMPs when Medicare determines that an individual or entity has violated Medicare rules and regulations. CMS maintains responsibility for implementing CMPs that involve program compliance, whereas the OIG maintains responsibility for implementing CMPs that involve threats to the integrity of the Medicare Program (such as fraud or false representation). The following are some examples of violations for which CMPs and additional assessments may be imposed (and in some instances exclusion from the Program may apply):

- Violation of the Medicare assignment provisions
- Violation of the Medicare physician, provider, or supplier agreement
- False or misleading information expected to influence a discharge decision
- Violation of assignment requirement for certain diagnostic clinical laboratory tests
- Violation of requirement of assignment for nurse anesthetist services
- Supplier refusal to supply rental DME supplies without charge after rental payments may no longer be made
- Physician billing for assistants at cataract surgery without prior approval of the QIO
- Hospital unbundling of outpatient surgery costs
- Hospital/responsible physician “dumping” of patients based upon their inability to pay or lack of resources

Typically, penalties involve assessments of significant damages such as CMPs up to $10,000 per violation and exclusion from the Medicare Program for a minimum of 5 years.

HOW DOES THE FRAUD INVESTIGATION PROCESS WORK?

Providers have a legal obligation to conform to the requirements of the Medicare Program. While most individuals or organizations are honest and make every effort to adhere to the guidelines set forth in the Medicare Program, some may be dishonest. Further, the high monetary amount billed to the Medicare Program makes it vulnerable to individuals who may inappropriately administer medical and health care services or bill for services never rendered. CMS must take strong action to combat fraud and protect the Medicare Trust Fund. The goal is to make sure Medicare only does business with legitimate providers who will furnish Medicare beneficiaries with needed high quality services.

The effort to prevent and detect fraud is a cooperative one that involves:

- CMS
- Medicare beneficiaries
- Medicare Contractors
- Physicians, suppliers, and other providers

- Quality Improvement Organizations (QIOs)
- State and federal law enforcement agencies such as the Office of Inspector General (OIG) of the Department of Health and Human Services (HHS), the Federal Bureau of Investigation (FBI), and the Department of Justice (DOJ)

Beneficiaries and physicians, suppliers, and other providers can and should report instances of suspected or potential fraud to Medicare. CMS and the other agencies listed above have a responsibility to perform the following tasks:

- Identify cases of suspected fraud
- Investigate suspected fraud cases thoroughly and in a timely manner
- Take immediate action to ensure that Medicare Trust Fund dollars are not inappropriately paid out and that any payments made in error are recouped

Suspension and denial of payments and the recoupment of overpayments are only some of the possible actions. When appropriate, cases are referred to the OIG Office of Investigations Field Office for consideration of criminal actions and initiation of CMPs or administrative sanctions (i.e., exclusion from participation in the program).

According to a 1993 survey by the Health Insurance Association of America of private insurers' health care fraud investigations, overall health care fraud activities are shown in Figure 5-1.

Fraud committed against the Medicare Program may be prosecuted under various provisions of United States Code and could result in the imposition of restitution, fines, and possibly imprisonment. In addition, there is also a range of administrative sanctions and CMPs that may be imposed when facts and circumstances warrant such action.

Individuals or organizations identified as engaging in potentially inappropriate activities are not subject to automatic prosecution. Stewards of the Medicare Program (i.e., the federal government, its agencies, and its contractors) are required to be prudent and treat providers fairly when making decisions that will affect them or their organizations.

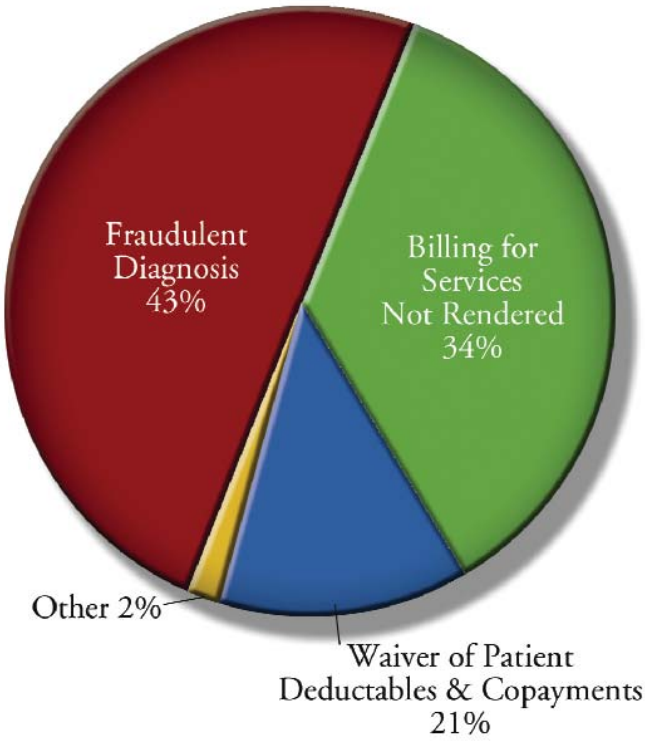

Figure 5-1. Breakdown of Common Fraudulent Activities

Investigation and prosecution of health care fraud are reserved for willful and intentional acts of wrongdoing, substantiated through documented inappropriate billing patterns. To address other inappropriate activities or payments, “safeguard” measures, rather than punitive measures, may be taken.

INVESTIGATIONS

In cases of substantiated allegations of fraud or suspected inappropriate activities, Medicare Contractors and/or federal law enforcement may investigate individuals and providers or suppliers for subsequent prosecution.

CRIMINAL PROSECUTIONS AND PENALTIES

Because it is a federal crime to defraud the federal government or any of its programs, individuals who commit fraud may be imprisoned, fined, or both. Criminal convictions typically include restitution and significant fines. In some states, providers and health care organizations may also lose their licenses. Convictions may also result in exclusion from Medicare participation for a specific length of time.

CIVIL PROSECUTIONS AND PENALTIES

The United States Attorney's Office may file a civil suit or decide that the interest of the Medicare Program is best served by settling a case. In these situations, the amount of damages plus additional money may be paid to the federal government in the form of penalties and fines. Depending on the severity of the case, the civil suit or settlement may include the following:

- Civil Monetary Penalty (CMP) to the federal government for no more than $10,000 for each item or service in non-compliance (or higher amounts where applicable by statute)
- Penalty assessment payment to the federal government for up to three times the amount claimed for each item or service in lieu of damages sustained by the federal government
- Exclusion from Medicare or any other federally funded program for a specified number of years
- Imposition of a “Corporate Integrity Agreement” with the federal government, whereby the individual or entity is required to accomplish specific goals (e.g., educational plan, corrective action plan, reorganization) and is also subject to periodic audits by the federal government

EXCLUSION AUTHORITY

The Office of Inspector General (OIG) has the authority to exclude (sanction) providers or suppliers who have been convicted of health care-related offenses. Even when the United States Attorney's Office declines to prosecute a case, the OIG may act to exclude the providers from the Medicare Program. The term “exclusion” means that, for a designated period, Medicare, Medicaid, and other government programs will not pay the provider for services performed or for services ordered by the excluded party.

In addition, under Title XI, Section 1128 [42 U.S.C 1320a-7] of the Social Security Act, many of the penalties imposed under this section may also cause exclusion from the Medicare Program. The authority to exclude providers and suppliers under this statute is delegated to CMS or the OIG, depending on which agency was delegated authority for the specific violation from the Secretary of the Department of Health and Human Services (HHS).

Title XI, Section 1128 [42 U.S.C. 1320a-7] of the Social Security Act also describes the mandatory and permissive exclusions discussed in the following sections.

Mandatory Exclusions

A mandatory exclusion exists if there is a conviction for fraud. Examples of mandatory exclusions can be found under Title XI, Section 1128(a) of the Social Security Act.

Permissive Exclusions

A permissive exclusion exists when there is no conviction for fraud; however, certain conditions and requirements have been met. Examples of permissive exclusions can be found under Title XI, Section 1128(b) of the Social Security Act.

Exclusion Information

A complete list of exclusions and other information related to exclusions is available at *www.oig.hhs.gov/fraud/exclusions.html* on the Web.

Payment Denials Due to Exclusion

Medicare will not pay an excluded individual or entity that has accepted assignment of a Medicare claim. Medicare also will not pay a beneficiary who submits claims for items and services furnished on or after the effective date of an exclusion (sanction) for services provided by an excluded party. In addition, Medicare will not pay for services/items furnished on the order or referral of an excluded individual or entity. An excluded party that submits claims for item or services furnished during the exclusion period is subject to Civil Monetary Penalty (CMP) liability under Title XI, Section 1128A(a)(1)(D) of the Social Security Act, in addition to denial of reinstatement to the Medicare Program.

Denial of Payment to a Supplier

Medicare will not pay for any items or services that an excluded party furnishes, orders, or prescribes. This payment prohibition applies to the excluded party and anyone who employs or contracts with the excluded party. The provider is ultimately responsible for establishing that the items and services billed were not furnished, ordered, or prescribed by an excluded individual.

Denial of Payment to a Place of Service (POS)

A POS that is wholly owned by an excluded party will not be paid by Medicare for services performed or items received (including services performed under contract) by an excluded party on or after the effective date of the exclusion.

Denial of Payment to Beneficiaries

If a beneficiary submits claims for items or services furnished by an excluded party or by a supplier that is wholly owned by an excluded party on or after the effective date of the exclusion:

- Medicare may pay for the first claim submitted by the beneficiary and will immediately give the beneficiary notice of the exclusion.
- Medicare will not pay the beneficiary for items or services furnished more than 15 days after the date of the notice to the beneficiary or after the effective date of the exclusion, whichever is later.
- Medicare may pay for certain emergency items or services furnished by an excluded party under the medical direction, or on the request of an excluded party during the period of exclusion. The claim for emergency services must be accompanied by a sworn statement of the individual furnishing the items or services specifying the nature of the emergency and the reason that items or services were not furnished by an eligible party.
- Medicare will not pay claims for emergency items or services if items or services were provided by an excluded party, who, through employment or contractual arrangement, routinely provides emergency health care items or services.

Exceptions to Payment Denials

Payment is available for services or items provided up to 30 days after the effective date of the sanction for:

- Inpatient hospital services or post-hospital SNF services, or for items furnished to a beneficiary who was admitted to a hospital or SNF before the effective date of the exclusion
- Home health services or items furnished under a plan of treatment established before the effective date of the exclusion

The Medicare and Medicaid Patient and Program Protection Act of 1987 (Public Law 100-93) permits payment for an emergency item or service furnished by an excluded individual or entity.

REINSTATEMENT

At the conclusion of the designated period of sanction, an individual and/or entity may be eligible for reinstatement to the Medicare Program and may apply to OIG for reinstatement.

Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)

The OIG's sanctioned LEIE identifies individuals and entities that are excluded from Medicare reimbursement. The list includes the provider's specialty, notice date, and the end of the sanction period. The OIG LEIE also identifies individuals and entities that have been reinstated to the Medicare Program.

Accessing the LEIE

The OIG-sanctioned LEIE is available at *www.oig.hhs.gov/fraud/exclusions.html* on the Web.

Government Services Administration (GSA) Excluded Parties Listing System (EPLS)

The GSA was established by the Federal Property and Administrative Services Act. The GSA's role is to examine ways to improve the administrative services of the federal government. The GSA website contains debarment actions taken by various federal agencies, which are in addition to those of the OIG LEIE exclusions database.

GSA EPLS Lists

The GSA debarment, exclusion, and suspension lists for all federal agencies are available at *http://epls.arnet.gov* on the Web.

The EPLS website assists Medicare and Medicaid Contractors in verifying the eligibility of health care providers or entities seeking to participate in the Medicare and Medicaid Programs. CMS encourages individuals and entities to research the information on this website before:

- Adding a provider to a physician group or medical staff
- Purchasing supplies
- Considering involvement in a medical facility or other entity that may seek payment from Medicare

WHAT IS THE MEDICARE INCENTIVE REWARD PROGRAM (IRP)?

Section 203(b)(1) of HIPAA (Public Law 104-191) established the Medicare IRP to encourage others to report information on individuals and entities that are engaged in or have engaged in illegal acts or omissions (that constitute grounds for the imposition of a sanction under Title XI, Sections 1128, 1128A, or 1128B of the Social Security Act) or who have otherwise engaged in sanctionable fraud and abuse against the Medicare Program under Title XI of the Social Security Act.

The Medicare IRP pays an incentive reward to individuals who provide information on Medicare fraud and abuse or other sanctionable activities. The Medicare Program will make a monetary reward for information that leads to a minimum recovery of $100 of Medicare funds from individuals and entities determined by CMS to have committed sanctionable offenses. Only referrals from FIs and Carriers to OIG, made pursuant to the criteria set forth in Chapter 3, Section 10, of the *Medicare Program Integrity Manual* are considered sanctionable for the purpose of the Medicare IRP.

Obtaining Medicare IRP Information

Additional information regarding the Medicare IRP is available in the Medicare Program Integrity Manual, Section 4.9, at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website. Search for publication #100-08.

Report or Ask Questions about Fraud and Abuse

To ask questions about fraud and abuse or to report suspected fraudulent or abusive activities, providers are encouraged to contact their Medicare Contractor or to call HHS/OIG directly at 1-800-HHS-TIPS (1-800-447-8477). TTY/TDD users should call 1-800-377-4950.

Specific criteria inform Medicare Contractors that they have a duty to identify cases of suspected fraud and to make referrals of all such cases to OIG, regardless of dollar thresholds or subject matter. Matters should be referred when the contractor has a reasonable basis to suspect that the provider has done any of the following:

- Intentionally engaged in improper billing
- Submitted improper claims with actual knowledge of their falsity
- Submitted improper claims with reckless disregard or deliberate ignorance of their truth or falsity

In cases where providers' employees submit complaints, such cases should be forwarded to OIG immediately. The amount of the reward will not exceed 10% of the overpayment recovered in the case or $1,000, whichever is less. Collected fines and penalties are not included as part of the recovered money for purposes of calculating the reward amount.

WHAT ARE SOME EXAMPLES OF FRAUD AND ABUSE CASES?

The following sections provide examples of some enforcement actions the federal government took in actual cases involving Medicare institutional providers and/or individuals employed by or having arrangements with institutional providers.

ADMINISTRATIVE ACTIONS

The following items describe Civil Monetary Penalties (CMPs) that were assessed based on false and fraudulent claims:

- June 2004 - After a Pennsylvania hospital self-disclosed conduct to the Office of Inspector General (OIG), the hospital agreed to pay $61,699 for allegedly violating the Civil Monetary Penalty Law (CMPL). The OIG alleged that the hospital employed a Registered Nurse that was excluded from participating in federal health care programs.
- April 2004 - After a Virginia health system self-disclosed conduct to the OIG, the health system agreed to pay $125,494 for allegedly violating the CMPL. The OIG alleged that the health system employed two individuals and contracted with a physician that were excluded from participating in federal health care programs.
- February 2004 - After a South Carolina hospital that provides home health, DME, and hospice services self-disclosed conduct to the OIG, the hospital agreed to

pay $9,491,191 to resolve its liability under the CMPL provisions applicable to false or fraudulent claims. The OIG alleged that the hospital inappropriately billed federal health care programs for home health visits, DME, and hospice care. The OIG alleged that claims were improper because visits were not documented, the need for skilled nursing care was not documented, supplies were billed when they were not ordered or documented, visits to patients were inconsistent with physicians' orders, physician signatures had not been obtained on certifications and plans of care, verbal orders were not properly documented, homebound status was not consistently documented, medications and supplies were not ordered or documented, Certificates of Medical Necessity (CMNs) were incomplete or otherwise defective, and the provision of oxygen was inconsistent with physicians' orders.

- November 2001 - A Pennsylvania hospital agreed to pay $270,000 to resolve its liability under CMPL provisions applicable to false or fraudulent claims. The OIG alleged that the hospital submitted claims for Emergency Department services personally and identifiably provided by faculty physicians to Medicare beneficiaries when there was insufficient documentary evidence to establish the presence of the physicians during the performance of these services.

The following item describes Civil Monetary Penalties (CMPs) that were assessed based on kickback and physician self-referrals:

- March 2004 - After a Colorado Skilled Nursing Facility (SNF) self-disclosed conduct to the OIG, the SNF and its medical director agreed to pay $23,000 to resolve their liability under CMPL provisions applicable to physician self-referrals. The OIG alleged that the medical director of the SNF was one of the owners of an investment firm that was the licensed operator of the SNF and also was the attending physician for some of the SNF's residents. The OIG alleged that the SNF billed Medicare for designated health services provided to its residents pursuant to the orders of the medical director.

CRIMINAL ACTIONS

The following items describe criminal monetary penalties that were assessed based on false and fraudulent claims:

- January 2004 - In Minnesota, the last subject in a complex home health care investigation was sentenced. The woman, a director of nursing, pled guilty and was ordered to pay $53,000 in restitution for health care fraud. Through the woman's involvement in the scheme, home health services were billed that were provided to beneficiaries who were not homebound and/or that were not medically necessary.
- April 2003 - In Maine, a man was sentenced to one year and one day in prison and was ordered to pay $274,000 in restitution and fines for causing a false cost report and a false tax return. The man, who created a physician group to provide services at a hospital where he served as chairman of the board, failed to disclose his consulting agreement, whereby his company paid him $350,000 a year that resulted in the hospital's failure to include services as a "related party" on its Medicare and Medicaid cost reports from 1994 through 1997. In addition, the man failed to disclose his consulting fees on his personal income tax returns from 1995 through 1997.
- March 2003 - A New York physician was sentenced to 6 months imprisonment and ordered to pay $250,000 in restitution for health care fraud. The owner of a clinic billed Medicare using the physician's Medicare provider number. In return for the use of his provider number, the owner of the clinic paid the physician $2,500 a month and let him utilize office space and

billing staff at the clinic. As a result, the owner received payments from Medicare for physical therapy services he was not qualified or legally allowed to perform and for services that were not provided.

- February 2003 - In Missouri, six co-defendants were sentenced for conspiring to defraud the United States through a system of kickbacks for patient referrals and the filing of false claims that resulted in overpayments from Medicare and Medicaid. The sentenced individuals included a licensed medical doctor, an RN, a billing service owner, an employee who provided medical billing services, and two owners of several residential care facilities and Home Health Agencies (HHAs). The six were ordered to pay respective restitution amounts totaling $526,000, and four were sentenced to prison. One central aspect of the scheme involved the owners' referral of patients from their residential facilities to doctors in exchange for them to certify the patients as homebound and eligible for their home health services. This arrangement allowed the doctors to bill Medicare and Medicaid for patient visits and the HHAs to bill Medicare and Medicaid for providing home health services.

NOTES

Section 6: Troubleshooting Claim Denials and Claim Rejections

Proper payment of Medicare claims is a result of the joint efforts of the provider, employee clinicians, and billing personnel. This goal requires meeting the Medicare Contractor's payment policy requirements that combine national and local policy. This section introduces common claim errors that result in claim rejections or claim denials and describes the general requirements for properly resubmitting rejected claims or appealing a denied claim.

If a claim is not paid as submitted, there are three general types of deficiencies identified by the Medicare Contractor:

- Billing/data entry errors
- Noncompliance with coverage policy
- Billing for services that are not medically necessary

In many cases, the claim either cannot be paid as initially submitted or is adjusted or denied because the Medicare Contractor requires additional documentation or a correction to the claim data.

WHAT CONSTITUTES A BILLING/DATA ENTRY ERROR?

Billing or data entry errors are generally described as errors and/or omissions contained within the Form CMS-1450 claim form itself (or the electronic claim equivalent). Omissions generally indicate that required fields were left blank [e.g., no International Classification of Disease, 9th Revision, Clinical Modification (ICD-9-CM) admitting diagnosis code entered in Field Locator (FL)/Block 76 of Form CMS-1450]. Errors could occur in situations where improper bill types are entered. One such example is a claim submitted with a discharge bill type (FL/Block 4) but the status code (FL/Block 22) indicates that the patient is still in the facility.

Acceptable Electronic Claim Formats

Electronic claims must comply with Health Insurance Portability and Accountability Act (HIPAA) electronic filing standards. A crosswalk of paper claim items to the corresponding electronic claim fields is available at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website. Search for publication #100-04. This crosswalk is also included within Reference B.

Claims that pass initial edits, commonly known as *front-end edits* or *pre-edits*, are processed according to Medicare policy and guidelines. However, the following claim errors identified by the Medicare Contractor's automated systems can result in claim rejections or denials:

- Beneficiary name/Health Insurance Claim Number (HICN) do not match
- Beneficiary's sex is incorrect or missing
- Billing provider identification number is incorrect
- Diagnosis code is invalid/missing

- Late-filing error
- Provider number is incorrect
- Modifier is missing, incorrect, or invalid
- Healthcare Common Procedure Coding Systems (HCPCS) code is invalid or missing
- Quantity billed is missing or incorrect

Each data entry error is described in the following tables and suggestions are provided for resolving the issue. Table 6-1 contains common billing errors affecting providers.

Durable Medical Equipment Regional Carrier (DMERC) HCPCS Coding Resources

DMERC coding questions can be directed to the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) Help Line at 1-877-735-1326.

Table 6-1. Common Billing Errors Affecting Institutional Providers

Beneficiary Name/Health Insurance Claim Number (HICN)/Sex Error:
The Medicare beneficiary name, HICN, and sex are required information. This information is often incorrect for one of the following reasons: ❖ The Medicare beneficiary's name is misspelled or does not match the beneficiary name CMS has on file ❖ The Medicare beneficiary's HICN is incorrect, incomplete, or missing ❖ The Medicare beneficiary's sex is incorrect or missing
Resolution:
1. Verify the Medicare beneficiary's name, HICN, and sex against the red, white, and blue Medicare Health Insurance card. The beneficiary's name on the claim must match the name on the Medicare Health Insurance card. 2. Enter the Medicare beneficiary's first and last name in FL/Block 12 of Form CMS-1450 or the electronic claim equivalent (see Reference B). The name must be alphabetic. 3. Enter the HICN in FL/Block 60 of the Form CMS-1450 or the electronic claim equivalent (see Reference B). The nine characters must be numeric. The 10th character must be alphabetic (no space). The 11th and 12th characters must be alpha-numeric (no spaces). Medicare numbers issued by the RRB may contain the insured's SSN or a 6-digit number (zeros may be added at the beginning to bring it to 9 digits). Regardless of the length of the number, the insured's number will always have an alpha prefix (with one or more characters). 4. Enter the beneficiary's sex in FL/Block 15 of Form CMS-1450 or the electronic claim equivalent (see Reference B). Valid values: Female (F), Male (M), or Unknown (U). 5. If the beneficiary indicates that his or her name on the Medicare Health Insurance Card is incorrect, direct the beneficiary to the local Social Security Office to have a corrected card issued.

Billing Provider Identification Number Error:

The payment contractor-assigned group number/Provider Identification Number (PIN) of the billing provider is required. The PIN is often incorrect or missing.

Resolution:

1. Verify the group number/PIN.
2. Enter the group number/PIN in FL/Block 51 of Form CMS-1450 or the electronic claim equivalent (see Reference B).

Diagnosis Error:

ICD-9-CM diagnosis codes are required information for **all hospital providers billing outpatient services**. This information is often considered incorrect because the ICD-9-CM diagnosis code is missing or invalid.

Resolution:

1. Verify the ICD-9-CM diagnosis code.
2. Enter the principal claim ICD-9-CM diagnosis code, to the highest level of specificity (coding to the fourth or fifth digit) in FL/Block 67. FL/Block 68-75 of Form CMS-1450 is for other claim diagnoses, and FL/Block 76 is for the admitting diagnosis, when appropriate (see Reference B).

Late Filing Error:

Medicare claims must be filed within certain time limits or the service(s) will be denied. A late claim cannot be resubmitted, but must first be appealed with appropriate supporting documentation to demonstrate timely filing.

Resolution:

Medicare law requires that a claim for services be filed no later than the end of the Calendar Year (CY) following the year in which the service was furnished, with the exception of services furnished in the last 3 months of the year. Services furnished within the last 3 months of a year must be filed by December 31st of the year following the year in which the services were furnished.

Example:

Services provided between October 1, 2003, through September 30, 2004, must be filed by December 31, 2005.

Unique Physician Identification Number (UPIN) Error:

The UPIN and name of the referring physician are required information when a claim involves referring and/or ordering physician services. This information is often incorrect for the following reasons:

- The referring/ordering physician UPIN and/or name was missing
- The referring/ordering physician UPIN and/or name used is invalid for the services referred (e.g., chiropractic services, self-referred consultations)

Resolution:

1. Verify the referring physician's UPIN at the time of referral.
2. Enter the referring/ordering physician's name and UPIN in FL/Block 82 of Form CMS-1450, or the electronic claim equivalent (see Reference B).
3. Ensure the referring physician's name and/or UPIN are valid for a referral of the Type of Service (TOS) rendered.
4. Check the UPIN directory available at *www.upinregistry.com* on the Web.

Modifier Errors:

Modifiers are 2-digit codes that can be added to a HCPCS code and are entered on the claim form to modify payment of a procedure, to assist the Medicare payment contractor in determining the appropriate coverage, or otherwise identify the detail being billed. This information is often incorrect for the following reasons:

- An inappropriate modifier is used
- An invalid modifier is used
- An appropriate modifier is missing

Resolution:

1. Verify what modifier should be used, if any.
2. Enter the appropriate modifier into FL/Block 44 of Form CMS-1450, or the electronic claim equivalent (see Reference B). The modifier goes after the HCPCS code.
3. Verify that a HCPCS code is present if a modifier is used.

Procedure Code Error:

The services rendered are identified by HCPCS codes. This information is often incorrect because the HCPCS code(s) is missing or invalid.

Resolution:

1. Verify the HCPCS code(s). The code must be valid for the date of service.
2. Enter the HCPCS code(s) in FL/Block 44 of Form CMS-1450, or the electronic claim equivalent (see Reference B).

Quantity Billed Error:

This value is the unit of services. The services must be equal to or greater than "1". The services cannot be greater than "99". For example, one unit equals "0001". This information is often incorrect for the following reasons:

- The quantity billed is missing
- The quantity billed does not correspond with the multiple visit dates entered
- For anesthesia, the elapsed time (hours) has not been converted into minutes and the total minutes have not been given for a procedure
- The provider billed multiple units for procedure codes that are not time-based

Resolution:

1. Verify the quantity billed.
2. Enter the quantity billed in FL/Block 46 of Form CMS-1450, or the electronic claim equivalent (see Reference B).

A claim that is missing required information cannot be processed for payment. Claims that cannot be processed and are denied are explained on the Remittance Advice (RA) (see Section 3, "What Is A Remittance Advice?"). The RA will contain Claims Adjustment Reason Codes and RA Remark Codes that describe why the claim was denied. If the denial is due to a billing or data entry error, the denied claim may be adjusted and resubmitted. If the denied claim cannot be adjusted, a new claim can be submitted. If a claim goes to the Return to Provider (RTP) file, the provider may make corrections to the claim on-line and re-suspend the claim for payment. Claims that go to the RTP file will not show up on an RA.

Approved Claims Adjustment Reason and RA Remark Codes

The master lists of approved Claims Adjustment Reason Codes and RA Remark Codes are updated during March, July, and November. The latest master list of Remark Codes is available at *www.wpc-edi.com/codes* on the Web.

HOW ARE COVERAGE POLICY COMPLIANCE ISSUES IDENTIFIED?

Medicare Contractors may identify errors in coverage policy compliance by utilizing automated systems that use logic programming to match code combinations (e.g., ICD-9-CM codes with HCPCS codes) or through manual Medical Review (MR). Coverage policy denials are supported in statute under Title XVIII, Section 1862 of the Social Security Act.

Social Security Administration (SSA) Coverage Policy Denial Information

Additional information regarding SSA coverage policy denials is available at *www.ssa.gov/OP_Home/ssact/title18/1862.htm* on the Web.

A provider must be aware of the following types of coverage policy under Medicare:

- Statutorily excluded services
- Regulations
- National Coverage Determinations (NCDs)

- Coverage provisions in interpretive manuals
- Local Coverage Determinations (LCDs)

Change to National Provider Identifier (NPI)

On January 23, 2004, the Department of Health and Human Services (HHS) published the Final Rule adopting the NPI as the standard unique health identifier for all health care providers, including individuals and organizations. Providers could begin applying for NPIs as of May 23, 2005. Further information on applying for and using the NPI and the NPI Final Rule can be found at *www.cms.hhs.gov/NationalProvIdentStand/* on the CMS website.

CMS Plans for Transitioning to the NPI in the Fee-for-Service Medicare Program:

For claims submitted on or before October 1, 2006, CMS systems will accept an existing legacy Medicare provider number **or** an NPI as long as it is accompanied by an existing legacy Medicare provider number.

Beginning October 2, 2006, and ending May 22, 2007, CMS systems will accept an existing legacy Medicare provider number **and/or** an NPI for HIPAA-covered entities such as providers completing electronic transactions, health care clearinghouses, and large health plans. This will allow for 6-7 months of provider testing before **only** an NPI will be accepted by the Medicare Program on May 23, 2007, for all providers except for small health plans. Small health plans must use only the NPI by May 23, 2008.

For additional information, to complete an NPI application, and to access educational tools, visit *https://nppes.cms.hhs.gov/NPPES/Welcome.do* on the Web.

TOP COMPLIANCE ISSUES RESULTING IN CLAIM DENIALS OR CLAIM REJECTIONS

Patient coverage may be denied or the claim rejected for the following reasons:

- The patient is not entitled to Medicare services
- The provider is not qualified to furnish the Medicare services billed
- Medicare is the secondary payer to other insurance
- Services are excluded by statute, national, or local coverage policy because:
  - There is no benefit for the service
  - The limited benefit is exhausted
- Claim/services do not meet technical requirements for payment (including national and local requirements). These include, but are not limited to:
  - Certification
  - Plan of care
  - Compliance with Correct Coding Initiative (CCI) edits

Eliminating Procedure Code Unbundling

Unbundling occurs when a procedure typically reported under a single comprehensive code is billed separately as multiple parts. This unethical act reflects improper procedure reporting under CCI coding requirements. CMS has identified numerous code pairs that would be rejected if billed for the same patient on the same day. In most unbundling cases, providers are not allowed to bill beneficiaries for amounts denied by Medicare. Providers should contact the FI or Carrier for information regarding circumstances when billing a beneficiary is allowed.

WHEN THE PATIENT IS NOT ENTITLED TO MEDICARE SERVICES

A provider should determine a patient's eligibility before providing services to help prevent a claim denial or claim rejection because the patient is not entitled to Medicare services. The provider can determine eligibility by obtaining a copy of the beneficiary's red, white, and blue Medicare Health Insurance card during his or her first visit or facility admission and confirming eligibility for the services to be furnished and billed. The provider can also determine eligibility electronically using the Fiscal Intermediary Shared System (FISS) and accessing the Common Working File (CWF). Providers can also use FISS to verify if a beneficiary is enrolled in a Medicare Advantage Plan (i.e., Medicare HMO).

Using the Fiscal Intermediary Standard System (FISS)

Providers can use FISS to verify Medicare eligibility and hospital and Skilled Nursing Facility (SNF) utilization days, and to access hospice and Medicare Secondary Payer (MSP) information. For additional information regarding FISS and to access the FISS Workbook on the Cahaba Qualified Medicare Beneficiary (QMB) website, see *www.iamedicare.com/Provider/newsroom/refguide/fiss_workbook.pdf* on the Web. After reading the licensing information, click the Accept button to continue and be redirected to information regarding FISS.

WHEN THE PROVIDER IS NOT QUALIFIED TO FURNISH THE MEDICARE SERVICES BILLED

A provider billing office must be aware of the status of not only their billing provider number, but also whether all physicians and clinicians furnishing and billing for Medicare covered services through the provider PIN are legally able to participate in the Medicare Program. Medicare will not pay for services furnished by excluded providers or for services furnished by employees of providers if those individuals have been excluded. In addition, facilities may be prohibited from submitting claims to Medicare in some situations for services furnished if an excluded employee is indirectly involved in the care of a Medicare beneficiary (e.g., an excluded Medical Director). It is the provider's responsibility to assure that he or she does not bill Medicare for services furnished by "excluded" individuals. For additional information regarding how providers can identify "excluded" individuals so that if they are employed within the provider's office they will not provide any Medicare services, refer to Section 5, "Exclusion Authority".

MEDICAL NECESSITY ISSUES

Errors in compliance with medical necessity policy may be identified by Medicare Contractors through routine or complex manual MR of a Medicare claim. During the MR process, the Fiscal Intermediary (FI) will request the hardcopy chart and medical information from the provider. Medical necessity denials are all statutorily supported under Title XVIII, Section 1862(a)(1)(A) of the Social Security Act. Denials based upon medical necessity determinations can always be appealed.

SSA Medical Necessity Denial Information

Additional information regarding medical necessity denials supported by the Social Security Act is available at *www.ssa.gov/OP_Home/ssact/title18/1862.htm* on the Web.

Medicare Contractors (FIs) and Program Safeguard Contractors (PSCs) are responsible for determining medical necessity. If a provider or supplier' claim is denied based on medical necessity, the applicable LCD should be reviewed for additional information.

HOW ARE CLAIMS RETURNED FOR CORRECTION?

Fiscal Intermediaries (FIs) use the Fiscal Intermediary Shared System (FISS) to electronically return claims (i.e., the Form CMS-1450) to the provider for correction. This file sent to the provider for correction is called the Return to Provider (RTP) file. Providers with electronic capability can access, correct, and resubmit these claims to the FI online. Claims can also be corrected through a telephone reopening of the claim (see Section 7, "Can A Minor Claim Error Be Corrected Without A Formal Appeal?"). Some of the more common reasons for a claim to be returned to the provider for correction are use of incorrect diagnosis codes, the beneficiary HICN and name do not match, or the claim is out of sequence. Claims within the RTP file will not show up in a Standard Paper Remittance (SPR) or an Electronic Remittance Advice (ERA) because they have not been processed. If the provider does not correct the RTP claim, the RTP claim will be dropped from the system in approximately 35 days.

NOTES

Section 7: Appealing Medicare Claim Denials

The recently updated appeals process is now the same for both Medicare Part A and Part B claims with respect to the amount of time the provider has in which to file an appeal. The current appeals process is depicted in Figure 7-1.

Updated Appeals Policy Information

Updated appeals policy is available in the Interim Final Rule dated March 8, 2005, which is available at *www.cms.hhs.gov/quarterlyproviderupdates/downloads/CMS4064IFC.pdf* and the correcting amendment which is available at *www.cms.hhs.gov/quarterlyproviderupdates/downloads/CMS4064IFC2.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.

Information regarding Medicare Advantage Fast Track Appeals and grievances for a beneficiary whose Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) coverage is about end is available at *www.cms.hhs.gov/MMCAG* on the CMS website.

Information regarding the Notice of Discharge and Medicare Appeal Rights (NODMAR) for Medicare Advantage hospital inpatients is available at *www.cms.hhs.gov/BNI* on the CMS website.

Please note that the appeals process will continue to undergo modification as proposed changes are implemented and future changes

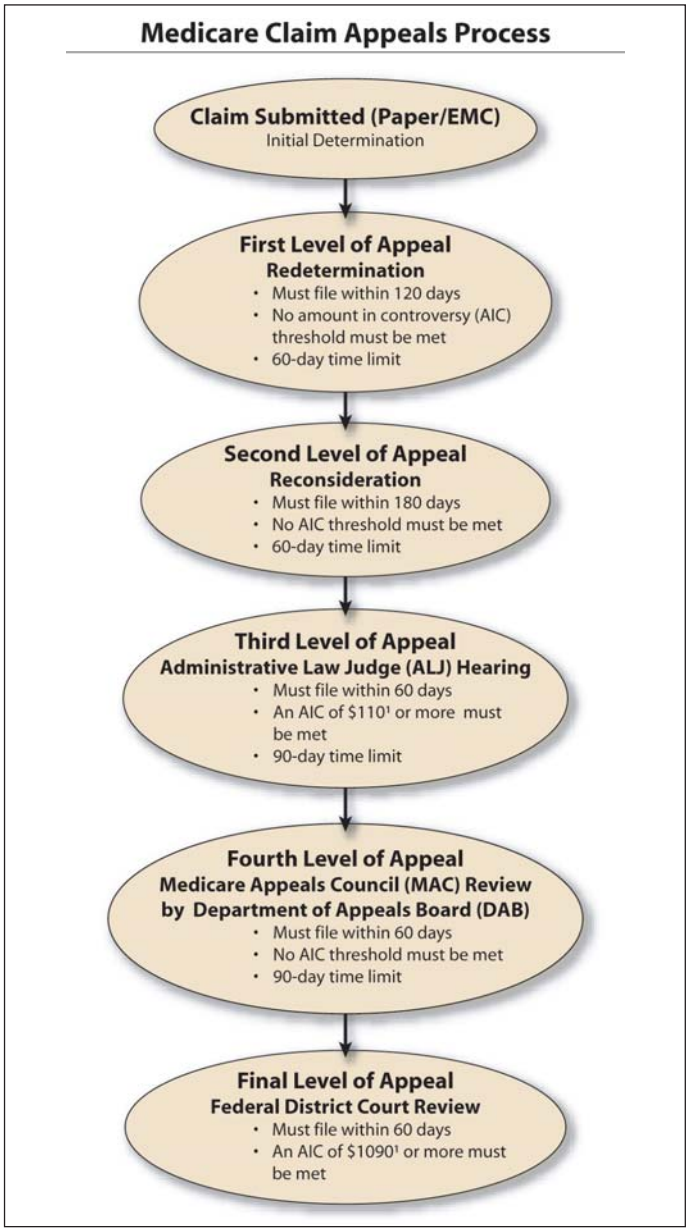

Figure 7-1. Medicare Claim Appeals Process

[1]As of 2005, the AIC requirement for an ALJ hearing and Federal District Court Review will be adjusted in accordance with the medical care component of the Consumer Price Index (CPI). The AIC threshold amounts for the 2006 Calendar Year (CY) are listed above.

are made in Medicare law. Before initiating an appeal, providers should confirm the current appeals process, including time limits and Amounts In Controversy (AICs) with their Fiscal Intermediaries (FIs).

CAN A MINOR CLAIM ERROR BE CORRECTED WITHOUT A FORMAL APPEAL?

Section 937 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) allows for providers, physicians, and other suppliers to correct minor errors and omissions without the need to initiate a formal appeal. Reopenings are separate and distinct from the appeals process. Medicare Contractors must process clerical errors and omissions as a reopening, rather than as a redetermination. Such reopenings may be handled over the telephone or in writing. As necessary, the FI may ask providers, physicians, or other suppliers to fax in additional documents to support changes and/or error corrections.

The following list provides examples of some errors that can be corrected during a reopening:

- Add, change, or delete certain modifiers
- Correct ICD-9-CM code(s)
- Correction to date(s) of service

Correcting Minor Claims Errors/Omissions

Information on correcting minor errors is available in the MLN Matters article at *www.cms.hhs.gov/MLNMattersArticles* on the CMS website. Search for MLN article SE0420.

The request to reopen a claim must be made within 1 year from the date of the notice of the initial determination. A provider has a 4-year time frame to initiate a reopening after the date of the initial determination if good cause exists.

If the FI receives a request for reopening and disagrees that the issue is a clerical error, the Medicare Contractor must dismiss the reopening request and advise the party of any appeal rights, provided the time frame to request an appeal on the original denial has not expired.

Assigning Medicare Appeals Rights to a Provider or Supplier

When Medicare denies a claim, the beneficiary has the right to legally assign appeal rights to a provider or supplier who was not already a party to the initial determination. This provider or supplier can then proceed with appealing the denied claim. The assignment of appeals rights must be made in writing using Form CMS-20031, which is available at *www.cms.hhs.gov/cmsforms/downloads/cms20031.pdf* on the CMS website.

WHAT IS THE FIRST LEVEL OF APPEAL?

After the initial determination has been made on a submitted Medicare claim, the first level of appeal is a *redetermination*. The purpose of a redetermination request is to contest the initial determination made on a Medicare claim. A redetermination is a new look at the claim and its supporting documentation by an FI who is independent of the reviewers who were originally involved with the initial claim determination. The request for a Medicare claim redetermination can be made in writing using the Medicare Redetermination Request Form (Form CMS-20027).

FILING A REDETERMINATION REQUEST

The appellant (the individual filing the appeal) must file a redetermination request in writing with the Medicare Contractor that processed the claim

Reconsideration by Qualified Independent Contractors (QICs)

Since May 1, 2005, all redeterminations by FIs (for Part A claims) have been subject to Qualified Independent Contractor (QIC) reconsideration, which may include a panel of medical professionals (see Section 7, "What Is The Second Level of Appeal?"). These appeals typically involve services furnished by hospitals, Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs).

As of January 1, 2006, all redeterminations by Carriers (for Part B claims) are subject to QIC reconsideration.

Additional information on QICs is available at *www.cms.hhs.gov/quarterlyproviderupdates/downloads/CMS4050NR.pdf* on the CMS website.

within 120 calendar days from the date the appellant receives the initial determination. There is no amount in controversy (AIC) threshold at this level of appeal. Medicare Contractors have 60 calendar days to render a decision. The redetermination request can be submitted using Form CMS 20027 available at *www.cms.hhs.gov/cmsforms/downloads/cms20027.pdf* on the CMS website.

Per Section 405.944(b) of the Interim Final Rule, the following information must be included within a written redetermination request that is not submitted on Form CMS-20027:

- Beneficiary's name
- Beneficiary's Medicare HICN
- Identification of the item or service for which the redetermination is being requested
- The specific date of service
- Name and signature of the requestor or the requestor's appointed representative

If any of the information listed above is missing from the redetermination request, the request will be returned to the provider with an explanation of what must be included.

SUBMITTING SUPPORTING DOCUMENTATION

It is very helpful and always necessary to submit an indication of why the service should be paid. The provider must include any documentation that is needed to conduct the redetermination, especially when submitting a written request for redetermination. Supporting documentation may include, but is not limited to:

- Nursing notes and initial assessments
- Physician progress notes
- Physician history and physicals
- Medication records
- A letter from the physician

If documentation that is needed to make a redetermination is not included with the request, the documenation may be requested from the provider. The provider must submit any supporting documentation at the redetermination level. In the case where documentation is presented after the request has been submitted, the Medicare Contractor's 60-day decision-making time frame is extended for up to 14 calendar days for each submission.

NOTIFICATION OF REDETERMINATION OUTCOME

Written notification of the outcome of the redetermination will be mailed to all parties to the appeal. Notification will be sent within 60 calendar days of receipt of the appellant's request for review (unless applicable extensions apply). This notification will be in the form of a letter, a Medicare Summary Notice (MSN) sent to the beneficiary, or a Remittance Advice (RA). If all services in question are paid, then the parties will receive a revised MSN or RA; however, if any

service in question is partially or fully denied, the outcome of the redetermination will come in the form of a letter.

WHAT IS THE SECOND LEVEL OF APPEAL?

A *reconsideration* is the second level of appeal for parties who are dissatisfied with the outcome of a redetermination. For all FI redeterminations issued on or after May 1, 2005, appellants have the right to request reconsideration by a QIC within 180 calendar days from the date the appellant receives notice of the redetermination decision. QICs are independent contractors who have been awarded contracts to review denied claims for Part A, Part B, or Durable Medical Equipment (DME) within the specific geographical area of the United States for which the QIC will process claims appeals. The request must be filed with the QIC specified in the Medicare Redetermination Notice (MRN). If the QIC does not issue a reconsideration within the established 60-day limit, the appellant can escalate the appeal to the Administrative Law Judge (ALJ) level.

FILING A RECONSIDERATION REQUEST

The following requirements must be met to receive a reconsideration;

- A request for hearing must be in writing and signed by the requestor.
- The request must be filed with the QIC within 180 calendar days from the receipt date of the redetermination outcome or within the requested time frame extension as the QIC might allow for good cause.
- The request for reconsideration can be submitted using Form CMS-20033 available at *www.cms.hhs.gov/cmsforms/downloads/cms20033.pdf* on the CMS website.

Per Section 405.964(b) of the Interim Final Rule, the following information must be included within a written reconsideration request that is not submitted on Form CMS-20033:

- Beneficiary's name
- Beneficiary's Medicare HICN
- Identification of the item or service for which the redetermination is being requested
- Name and signature of the requestor or the requestor's appointed representative
- Name of the Medicare Contractor that made the redetermination

If any of the information listed above is missing from the reconsideration request, the request will be returned to the provider with an explanation of what must be submitted.

NOTIFICATION OF RECONSIDERATION OUTCOME

Written notification of the outcome of the reconsideration will be mailed or otherwise transmitted to all parties who filed the request for reconsideration. Notification will be sent within 60 calendar days of receipt of the appellant's request for review (unless applicable extensions apply).

If the reconsideration results in the issuance of supplemental payment to a provider or supplier, the Medicare Contractor must also issue an electronic or paper RA notice to the provider or supplier. In the event of an overpayment case involving multiple beneficiaries who have no liability, the QIC may issue a written notice only to the appellant.

WHAT IS THE THIRD LEVEL OF APPEAL?

If a party to the reconsideration is dissatisfied with the decision and the AIC is at least $100, the party can request a hearing before an Office of

Medicare Hearings and Appeals (OMHA) *Administrative Law Judge (ALJ)*. As of January 1, 2005, the AIC is adjusted annually in accordance with the percentage increase in the medical care component of the Consumer Price Index (CPI) for all urban consumers and rounded to the nearest multiple of $10. For Calendar Year (CY) 2006, the AIC must be at least $110. The request must be submitted within 60 calendar days of his or her receipt of the reconsideration decision. This function is currently performed by ALJs employed by the OMHA.

The ALJ hearing results in a new decision by an independent adjudicator. If the OMHA ALJ does not reach a decision within the 90-day deadline beginning on the date the request for hearing is received by the entity specified in the QIC's reconsideration notice, the party may request a Medicare Appeals Council (MAC) review by the Department of Appeals Board (DAB). Expedited access to MAC review can be granted if the MAC does not have authority to decide questions of law or regulation relevant to matters in controversy and there is no material issue of fact in dispute.

FILING AN ALJ HEARING REQUEST

To request an ALJ hearing, the requestor must file a written request for an ALJ hearing within 60 calendar days from the date of receipt of the QIC's reconsideration. The request must be filed with the OMHA specified in the QIC's reconsideration. The requestor should use Form CMS-20034A/B to submit a request, available at *www.cms.hhs.gov/cmsforms/downloads/cms20034ab.pdf* on the CMS website.

Per Section 405.1014(a) of the Interim Final Rule, the following information must be included within a written ALJ hearing request that is not submitted on Form CMS-20034A/B:

- Beneficiary name and address
- Medicare HICN of the beneficiary whose claim is being appealed
- Name and address of the appellant when the appellant is not the beneficiary
- Name and address of the designated representative, if any
- Document control number assigned to the appeal by the QIC, if any
- Specific dates of service
- Reason(s) for appeal of the QIC's reconsideration
- Statement of any additional evidence to be submitted and the date it will be submitted

If the request is not submitted within the 60-day limit and the requestor can demonstrate there is good cause that prevented timely submission of the request, the time frame for filing will be extended.

SUBMITTING EVIDENCE BEFORE THE ALJ HEARING

All written evidence should be submitted with the request for the hearing (or within 10 days of receiving notice of the hearing). If a party submits evidence after the 10-day period, the period between the time the evidence was submitted and the time the evidence is received is not counted toward the 90-day adjudication deadline. Any evidence submitted by a provider, supplier, or beneficiary represented by a provider or supplier that is not submitted prior to issuance of the QIC's reconsideration determination must be submitted with a statement explaining why the evidence was not previously submitted to the QIC or a prior decision-maker.

NOTICE OF ADMINISTATIVE LAW JUDGE (ALJ) REVIEW DECISION

Unless the ALJ has dismissed the hearing, a decision will be mailed to all parties to the hearing, to the QIC that issued the reconsideration determination in question, and to the Medicare Contractor that issued the initial determination. For overpayment cases involving

multiple beneficiaries where there is no beneficiary liability, the ALJ may send written notice only to the appellant. In the event a payment will be made to a provider or supplier in conjuction with the ALJ decision, the Medicare Contractor must also issue a revised electronic or paper RA to that provider or supplier.

WHAT IS THE FOURTH LEVEL OF APPEAL?

After an ALJ hearing decision has been made on a Medicare claim, the next level of appeal is a *Medicare Appeals Council (MAC) review* by the Departmental Appeals Board (DAB). A request for MAC review must be filed with the DAB within 60 calendar days of receipt of the ALJ hearing decision or dismissal. There is no AIC to meet at this level of appeal. The request for MAC review must be submitted in writing using Form DAB-101.

Per Section 405.1112(a) of the Interim Final Rule, the following information must be included within a written MAC review by DAB request that is not submitted on Form DAB-101:

- Beneficiary name and address
- Medicare HICN of the beneficiary whose claim is being appealed
- Specific dates of service
- Specific service(s) or item(s) for which the review is requested
- Date of the ALJ's final action (if any) or the hearing office in which the appellant's request for hearing is pending (if requesting escalation from the ALJ to the MAC)
- Name and signature of the party or representative of the party to the appeal

If the request is not submitted within the 60-day limit and the requestor can demonstrate there is good cause that prevented timely submission of the request, the time frame for filing will be extended.

Obtaining a Medicare Appeals Council (MAC) Review Request Form

Form DAB-101 can be downloaded at *www.hhs.gov/dab/DAB101.pdf* on the CMS website.

Submitting a MAC Review by the DAB

A request for a MAC review should be submitted to the following address:

Department of Health and Human Services
Department of Appeals Board, MS 6127
Medicare Appeals Council
300 Independence Avenue, SW,
Room G-644
Washington, D.C. 20201

A request for review can also be faxed to 202-565-0227. After submitting a request for a MAC review, inquiries regarding the request can be directed to 202-565-0100.

SUBMITTING ADDITIONAL EVIDENCE

When a MAC is reviewing an ALJ's decision, the MAC is limited to reviewing only evidence contained in the record of the proceedings before the ALJ. However, if the hearing decision decides a new issue that the parties were not afforded an opportunity to address at the ALJ level, the MAC considers any evidence related to that issue that is submitted with the request for review.

If the MAC determines that additional evidence is needed to resolve the issue(s) of a case and the hearing record indicates that previous decision-makers did not attempt to obtain the evidence, the MAC may remand the case to the ALJ to obtain the evidence and issue a new decision.

If the appeal is a result of an appellant's request for escalation, the ALJ will base their decision on the record constructed at the QIC level and any additional evidence (including oral testimony) entered into the record by the ALJ before the case was escalated.

For additional information regarding the submission of evidence at the MAC level of appeal, please refer to the Interim Final Rule dated March 8, 2005, which is available at *www.cms.hhs.gov/quarterlyproviderupdates/downloads/CMS4064IFC.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.

NOTIFICATION OF MEDICARE APPEALS COUNCIL (MAC) REVIEW DECISION

The MAC decision will be mailed within 90 calendar days of submission of the request for MAC review to all parties. If the MAC fails to provide a decision to the entity or entities that filed the request for MAC review within 90 calendar days of receipt of the appellant's request for review (unless applicable extensions apply), the appellant may submit a request for escalation to the next level of appeal. For overpayment cases involving multiple beneficiaries where there is no beneficiary liability, the MAC may choose to send written notice only to the appellant. In the event the decision will result in payment to a provider or supplier, the Medicare Contractor must issue an electronic notice or paper RA to that provider or supplier.

WHAT IS THE FIFTH LEVEL OF APPEAL?

If a requestor is dissatisfied with the MAC's decision, he or she must then commence civil action and request a *Federal District Court Review* within 60 calendar days of receipt of the MAC's decision. As of January 1, 2005, the AIC is adjusted annually in accordance with the percentage increase in the medical care component of the CPI for all urban consumers and rounded to the nearest multiple of $10. For CY 2006, the AIC must be at least $1,090 to request a Federal District Court Review. The requestor must file the complaint with the United States District Court, not the FI.

If the request is not submitted within the 60-day limit and the requestor can demonstrate there is good cause that prevented timely submission of the request, the time frame for filing will be extended.

NOTIFICATION OF FEDERAL DISTRICT COURT REVIEW DECISION

The Federal District Court may either reach a final decision or remand the case to the MAC or ALJ for further proceedings. In any case, written notification will be sent to all involved parties of the court's decision or remand. If the case is remanded to the MAC or ALJ, all parties will be notified in writing of the MAC or ALJ decision.

HOW CAN NATIONAL COVERAGE DETERMINATIONS (NCDS) AND LOCAL COVERAGE DETERMINATIONS (LCDS) BE CHALLENGED?

On December 8, 2003, CMS implemented a process that permits certain Medicare beneficiaries to challenge coverage policies that may prevent access to items and services or that have resulted in claim denials. These changes were required by Congress per Section 522 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act (BIPA) of 2000. Under this policy, a beneficiary who qualifies as an "aggrieved party" may challenge an LCD or an NCD (or specific provisions therein). Medicare defines an "aggrieved party" in 42CFR Section 426.110 as follows.

Aggrieved party means a Medicare beneficiary, or the estate of a Medicare beneficiary, who:

- Is entitled to benefits under Part A, enrolled under Part B, or both (including an individual enrolled in fee-for-service

Medicare, in a Medicare Advantage Plan, or in another Medicare managed care plan)

- Is in need for coverage for a service or item that is denied based upon an applicable LCD (in the relevant jurisdiction) or an NCD, regardless of whether the service or item was received
- Has obtained documentation of the need by the beneficiary's treating physician

As of January 1, 2004, any FI that denies a claim based on an LCD or NCD must notify the beneficiary of the denial and the reasons for the denial on the MSN.

How to Challenge an LCD or NCD

A beneficiary that qualifies as an aggrieved party may challenge an LCD or an NCD by filing a complaint with the office designated by CMS. Beneficiaries may obtain information regarding how to file a complaint by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

How to Challenge an LCD or NCD if Only a Beneficiary can Submit a Request for Review

Providers may continue to participate in the process of developing, revising, or discontinuing an LCD or NCD under existing policies. Section 4, "Introduction To The Medical Review (MR) Process", addresses the policy development process. Information for challenging an LCD or NCD is available at *www.cms.hhs.gov/Rulings/downloads/CMSR0101.pdf* on the CMS website. Contact the FI for additional information regarding how to challenge an LCD or NCD.

In this process, an aggrieved party may not assign legal rights to request a review of an LCD or an NCD to a third party (including a provider). However, a provider is permitted to assist the beneficiary in developing the initial request for review and in navigating the review process. This involvement of a third-party to offer assistance is not mandatory, and unless a provider is subpoenaed under existing regulations, there will be no monetary expenses reimbursed by Medicare.

CMS does not believe that the provisions of this process will have a significant effect on providers since Congress developed the BIPA 522 policy review process for beneficiaries. Providers may be requested, however, to supply documentation that an aggrieved party may need that pertains to a specific service, and to assist in representing an aggrieved party. In addition, the documentation necessary for the review may be in the form of an order or other existing language from the beneficiary's medical record, and need not be newly-created material. Overall, CMS believes that this rule will result in an insignificant economic impact on health care providers or the health care industry as a whole.

A favorable decision for the beneficiary may result in a previously denied claim being paid by Medicare. In addition, this process may result in a policy change in an LCD or NCD that will affect other beneficiaries in the future. However, the right to challenge NCDs and LCDs is distinct from the existing appeal rights for the adjudication of claims discussed in Section 7, "What is the Fifth Level of Appeal?". Thus, a beneficiary may elect to pursue a claims denial through the claims appeal process, seek review of an LCD or an NCD using this process, or both.

Section 8: Introduction to HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted to:

- Improve portability and continuity of health insurance coverage
- Combat waste, fraud, and abuse in health insurance and delivery of health care
- Promote the use of Medical Savings Accounts (MSAs)
- Improve access to long-term care services and coverage
- Simplify the administration of health insurance

The Centers for Medicare & Medicaid Services (CMS) is responsible for implementing and enforcing various unrelated provisions within HIPAA; therefore, HIPAA may have different meanings depending on the circumstances. The two HIPAA provisions addressed within this document pertain specifically to CMS are HIPAA Insurance Reform (Title I) and HIPAA Administrative Simplification (Title II).

WHAT ROLE DOES CMS HAVE WITH HIPAA?

CMS is responsible for implementing and enforcing the following provisions of HIPAA:

- **HIPAA Insurance Reform** - Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs.
- **HIPAA Administrative Simplification** - Title II of HIPAA requires the Secretary of the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. Title II also addresses the security and privacy of health data. Adopting these standards improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care. Although HIPAA was enacted in 1996, each provision of the Administration Simplification Act is set into motion through the issuance of proposed and final regulations. Thus, each part of the Administrative Simplification has different effective dates and different compliance deadlines. CMS is responsible for implementing and enforcing all Administrative Simplification provisions except privacy.

WHAT ARE THE ADMINISTRATIVE SIMPLIFICATION REQUIREMENTS?

The Administrative Simplification Requirements of HIPAA impact health care providers who do business electronically, as well as many of their health care business partners. Many changes involve complex computer system modifications.

The Administrative Simplification Requirements of HIPAA consist of four parts (see Table 8-1).

Information Regarding HIPAA Requirements and Coverage

For help in determining if a provider is a covered entity, access the decision tool at *www.cms.hhs.gov/HIPAAGenInfo/06_AreYouaCoveredEntity.asp* on the CMS website or access coverage information at *www.hhs.gov/ocr/hipaa/* on the Web.

For additional information regarding HIPAA requirements and coverage as a covered entity, contact HIPAA directly at *www.cms.hhs.gov/HIPAAGenInfo/01_Overview.asp* on the CMS website or by phone at 1-866-282-0659 (TTY/TDD users should call 1-877-326-1166).

The Administrative Simplification standards adopted by the Secretary of HHS under HIPAA apply to any entity that is:

- A health care provider that conducts certain transactions in electronic form or who use a billing service to conduct transactions on his or her behalf
- A health care clearinghouse (applies to all health care clearinghouses)
- A health plan (applies to all health plans)
- A Medicare Prescription Drug Card sponsor (until the Drug Card Program ends in 2006)

An entity that is one or more of these types is referred to as a "covered entity" and must comply with the Administrative Simplification requirements of the HIPAA regulations.

ELECTRONIC TRANSACTIONS AND MEDICAL CODE SETS

Under HIPAA, electronic transactions are allowed, provided that the transactions meet the established requirements. The requirements include adopting the national standards for electronic transactions and using standardized medical code sets used to encode data.

Table 8-1. HIPAA Administration Simplification Requirements

Electronic Transactions and Code Sets	Security	Unique Identifiers	Privacy
Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that national standards for certain health care electronic transactions and code sets be adopted and used.	HIPAA addresses how stored, transmitted, and accessed information should be secured.	HIPAA requires the adoption and use of identifiers for providers, health plans, and employers.	Under HIPAA, covered entities must implement standards to protect and guard against the misuse of individually identifiable health information. The privacy requirements are overseen by the Office of Civil Rights (OCR), an agency within the Department of Health and Human Services (HHS).

ELECTRONIC TRANSACTIONS

Transactions are activities that involve the transfer of health care information for specific purposes. Under HIPAA Administration Simplification, if a health care provider engages in one of the identified transactions, he or she must comply with the standard for that transaction. HIPAA requires every provider who does business electronically to use the same health care transaction standards, code sets, and identifiers. HIPAA has identified the following 10 National Standards for Electronic Data Interchange (EDI) for the transmission of health care data:

- Premium payments
- Enrollment in and disenrollment from a health plan
- Eligibility inquiry and response
- Referrals and authorizations
- Claims/encounters data
- Claim status inquiry and response
- Claim payment and Remittance Advice (RA)
- Coordination of Benefits (COB)
- First report of injury (pending)
- Claim attachments (pending)

Table 8-2 lists the current electronic standard requirements.

Table 8-2. Electronic Standard Requirements

Electronic Transactions Standards for:	
Claims or Encounters and Coordination of Benefits (COB)	Accredited Standards Committee (ASC) X12N 837 - Professional Health Care Claims ASC X12N 837 - Institutional Health Care Claims ASC X12N 837 - Dental Health Care Claims National Council for Prescription Drug Programs (NCPDP) - Telecommunication Version 5.1 and Batch Standard 1.1 - Retail Pharmacy Claims
Health Care Claim Payment and Remittance Advice (RA)	ASC X12N 835 - Health Care Claim Payment/Advice
Health Claims Status	ASC X12N 276/277 - Health Care Claim Status, Request, and Response
Eligibility for a Health Plan	ASC X12N 270/271 - Health Care Eligibility Benefit Inquiry/Response NCPDP - Telecommunication Version 5.1 and Batch Standard 1.1 - Retail Pharmacy Claims
Referral Certification and Authorization	ASC X12N 278 - Health Care Services Review - Request for review and response NCPDP - Telecommunication Version 5.1 and Batch Standard 1.1 - Retail Pharmacy Claims
Enrollment and Disenrollment in a Health Plan	ASC X12N 834 - Benefit Enrollment and Maintenance
Health Plan Premium Payments	ASC X12N 820 - Payment Order/RA

Transaction Standards, Final Rule Guidelines, Code Sets, and Identifier Information

Additional information regarding regulations governing transaction standards, Final Rule implementation guidelines, code sets, and identifier information can be found at *www.cms.hhs.gov/HIPAAGenInfo* on the CMS website.

HIPAA Implementation Guides

The HIPAA Implementation Guides may be downloaded for free at *www.wpc-edi.com/hipaa/HIPAA_40.asp* on the Web.

Standards have been developed for 8 of the 10 transactions. Transaction standards have not been developed for the first report of injury or for claim attachments.

Not every covered entity conducts all of the transactions. For instance, health care providers do not enroll and disenroll beneficiaries from a health plan.

The Standards Development Organizations (SDOs) have developed implementation guides to assist covered entities and their business associates. The implementation guides provide the adopted implementation specifications and comprehensive technical details for HIPAA implementation and include detailed technical specifications that explain how to conduct a standard transaction. These details and specifications include:

- Format specification - how information should be arranged
- Content specification - what information should be included
- Certain code sets - how information is included using representational codes

For example, the guides provide important information for an Information Technology (IT) group or vendor that handles electronic data exchange.

Providers should also contact their payers and inquire whether they have companion guides available to accompany the implementation guides. If available, companion guides can provide additional information that is helpful in interpreting the implementation guides.

STANDARD MEDICAL CODE SETS

In addition to transaction standards, HIPAA regulations also require the use of standard code sets. Medical code sets include any set of codes used for encoding data elements such as tables of terms, medical concepts, medical diagnoses, or medical procedure codes. The codes are an integral part of electronic transactions and are used to describe various health care services, procedures, tests, supplies, drugs, and patient diagnoses, as well as many administrative activities.

Evaluation and Management Service (E/M) Code Information

A description of E/M codes and the Documentation Guidelines that prescribe correct usage of the codes are contained within Chapter 6 of the *Medicare Resident and New Physician Guide*, which is available at *www.cms.hhs.gov/MLNProducts/MPUB/list.asp* on the CMS website.

HIPAA refers to code sets as either medical (clinical) codes or non-medical (non-clinical) codes. A subset of the Current Procedure Terminology (CPT) Codes includes a set of cognitive E/M Codes. All types of providers use these codes to document services performed during patient care. These codes explain how the physician gathered and analyzed information about the patient's illness, determined a condition, and devised the best treatment or course of treatment.

The transactions and code set regulation incorporated these first sets of HIPAA standards.

The regulation also created a process that allows individuals to request a change in the standards. The Secretary of HHS designated six organizations as Designated Standards Maintenance Organizations (DSMOs). These DSMOs have agreed to work together to collect requests for changes to HIPAA standards, evaluate the requests, and suggest changes to the standards for the Secretary's consideration.

DSMO Modification Process

The Secretary may modify a standard or its implementation guide no more than once every 12 months. The latest information on the DSMO process can be found at *www.hipaa-dsmo.org* on the Web.

The six DSMOs are:

- Accredited Standards Committee X12
- Dental Content Committee of the American Dental Association (ADA)
- Health Level Seven
- National Council for Prescription Drug Programs
- National Uniform Billing Committee (NUBC)
- National Uniform Claim Committee

Table 8-3 outlines the code sets that have been adopted under HIPAA.

Important Notice Regarding Use of ICD-9-CM Diagnosis Codes

As of October 1, 2004, International Classification of Disease, 9th Revision, Clinical Modification (ICD-9-CM) Diagnosis Codes can no longer be used for **Hospital** outpatient claims billing. Hospital providers must instead use Healthcare Common Procedure Coding System (HCPCS) Codes, which include the CPT Codes. For a full listing of HCPCS Codes, refer to *www.cms.hhs.gov/HCPCS ReleaseCodeSets* on the CMS website.

Also, please be aware that the 90-day grace period for using discontinued HCPCS Codes has been eliminated, and a claim containing a discontinued HCPCS Code will be denied.

Table 8-3. HIPPA-Adopted Medical Code Sets.

Code Type	Purpose
Diagnosis Codes	**For all non-hospital outpatient billing:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Codes, Vol. 1 & 2. These volumes are maintained by the Centers for Disease Control and Prevention (CDC). **NOTE:** Medicare will reject a claim that contains a diagnosis code that is not valid on the date of service.

Code Type	Purpose
Current Procedure Terminology (CPT)-4 Codes	Volume 4 of the CPT-4 Codes is used for services provided by physicians and other professionals. These codes are maintained and copyrighted by the American Medical Association (AMA).
Healthcare Common Procedure Coding System (HCPCS) Codes	**For hospital bill types 12x and SNF bill type 22x:** Codes used for products, supplies, and services not included in the CPT-4 Codes. These codes are maintained by the Centers for Medicare & Medicaid Services (CMS), Blue Cross Blue Shield Association (BCBSA), and the Health Insurance Association of America (HIAA).
Current Dental Terminology (CDT)-4 Codes	The Fourth Edition of the CDT Codes is used for dental procedures and nomenclature. These codes are maintained and copyrighted by the American Dental Association (ADA).
National Drug Codes (NDCs)	Codes used by retail pharmacies and maintained by the Food and Drug Administration (FDA) within the Department of Health and Human Services (HHS).
Claim Adjustment Reason Codes	Codes used to furnish information to explain why a claim or service line was adjusted or paid differently than it was billed [codes approved by the Accredited Standards Committee (ASC) X12 and maintained by the ASC X12N Code Maintenance Committee].
Remittance Advice (RA) Remark Codes	Codes used in conjunction with Claim Adjustment Reason Codes on a Remittance Advice (RA) to further explain an adjustment or to indicate if and what appeal rights apply. Additionally, there are some RA Remark Codes that are used to relay informational messages, even when there is no adjustment. RA Remark Codes are maintained by CMS, but may be used by any health care payer when appropriate. Any RA Remark Codes may be reported at the service-line level or the claim level, as applicable, on any Electronic Remittance Advice (ERA) or Standard Paper Remittance Advice (SPR).

Approved Claim Adjustment Reason and RA Remark Codes

The master lists of approved Claim Adjustment Reason Codes and RA Remark Codes are updated during March, July, and November. The latest master code lists are available at *www.wpc-edi.com/codes/remittanceadvice* on the Web.

HIPAA ELECTRONIC CLAIMS SUBMISSION REQUIREMENTS FOR PROVIDERS

HIPAA does not require all providers who are covered entities to submit claims electronically. HIPAA does require that if a provider is a covered entity and conducts certain transactions electronically, he or she must comply with HIPAA standards.

HHS recognizes that transactions often require the participation of two covered entities, and non-compliance by one covered entity may put the second covered entity in a difficult position.

Prior to October 1, 2005, claims filed in a non-compliant format were paid by CMS. **As of October 1, 2005,** any claim filed that does not meet HIPAA transaction standards is returned to the filer for resubmission using a HIPAA-compliant file format. Non-compliant claims will not be processed.

The phrase "provider of services" is defined for Medicare by Title XVIII, Section 1861(u) of the Social Security Act and includes seven specific types of institutional or special purpose providers. This term generally describes hospitals, nursing facilities, and other institutional providers that are paid through Medicare FIs. The terms found in the phrase "physician, practitioner, or facility" are used to describe entities that furnish Medicare services described in Title XVIII, Section 1861(s) of the Social Security Act and are generally paid through Medicare Carriers.

Claims Submission Information

Electronic Claims

Information regarding compliance with the latest electronic billing requirements is available at *www.cms.hhs.gov/ElectronicBillingEDITrans/01_overview.asp* on the CMS website.

Paper Claims

Information on the latest CMS regulations regarding the limited acceptance of paper claims in lieu of electronic billing is available at *www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp* on the CMS website.

Contingency Planning

Additional information regarding contingency planning guidelines is available at *www.cms.hhs.gov/ElectronicBillingEDITrans/17_Contingency.asp* on the CMS website.

SECURITY STANDARDS

On February 20, 2003, HHS published the Final Rule for Security Standards for electronic Protected Health Information (PHI). The Security Final Rule specifies a series of administrative, technical, and physical security safeguards for covered entities to use that assure the confidentiality, integrity, and availability of PHI in electronic format. The Security Final Rule adopts standards for the security of electronic PHI to be implemented by health plans, health care clearinghouses, drug card sponsors, and certain health care providers. The security standards improve the Medicare and Medicaid Programs, other federal health programs and private health programs, and the effectiveness and efficiency of the health care industry in general by establishing a level of protection for certain health care information.

COVERED ENTITY SECURITY REQUIREMENTS

Covered entities are required to maintain reasonable and appropriate administrative, physical, and technical safeguards to ensure the integrity, confidentiality, and availability of health information and to protect against any reasonably anticipated threats or hazards to the security and integrity of the information.

Covered entities must:

- Ensure the confidentiality, integrity, and availability of all electronic PHI that the covered entity creates, receives, maintains, or transmits
- Protect against any reasonable anticipated threats or hazards to the security or integrity of such information
- Define safeguards and procedures that protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required
- Ensure compliance with this Final Rule by its workforce

The security compliance date for all covered entities was April 20, 2005, except for small health plans that must be in compliance by April 20, 2006.

The security standards are:

- Scalable: All covered entities must be able to implement these standards. Covered entities are required to assess potential risks and vulnerabilities and implement reasonable and appropriate security protections. Protections implemented to comply with the standards must be kept current and must be documented.
- Technology neutral: The standards must withstand changes caused by evolving technology without becoming obsolete.

The security standards protect electronic data at rest and in transit. Specific examples of security standards include:

- **Administrative Safeguards**
  - Security management process
  - Assigned security responsibility
  - Workforce security
  - Information access management
  - Security awareness and training
  - Security incident procedures
  - Contingency plan
  - Evaluation
  - Business associate contracts and other arrangements
- **Physical Safeguards**
  - Facility access controls
  - Workstation use
  - Workstation security
  - Device and media controls
- **Technical Safeguards**
  - Access control
  - Audit controls
  - Integrity
  - Person and entity authentication
  - Transmission security
- **Organizational Requirements**
  - Business associate contacts and other arrangements
  - Requirements for Group Health Plans (GHPs)
- **Policies and Procedures and Documentation Requirements**
  - Policies and procedures
  - Documentation

Some of the specifications listed above are required, and some specifications can be addressed on a case-by-case basis.

Security Standards Information

Papers are available in the HIPAA Security Educational Paper Series. Topics include *Security 101 for Covered Entities, Security Standards - Administrative Safeguards, Security Standards - Technical Safeguards, and Security Standards - Organizational Policies and Procedures and Documentation Requirements.* These papers, as well as general information, Frequently Asked Questions (FAQs), and regulations and standards, are available at *www.cms.hhs.gov/EducationMaterials/04_SecurityMaterials.asp* on the CMS website.

Final Rule for Security Standards Information

Additional information on the Final Rule for Security Standards (updated text) can be found at *www.cms.hhs.gov/SecurityStandard/Downloads/securityfinalrule.pdf* on the CMS website.

Unique Identification Information

The latest information on unique identifiers can be found at *www.cms.hhs.gov/NationalProvIdentStand/01_overview.asp* on the CMS website.

UTILIZING UNIQUE IDENTIFIERS

HIPAA requires the adoption and use of the following unique health identifiers in standard transactions:

- Employer identifier
- Provider identifier
- Health plan identifier

EMPLOYER IDENTIFIER

The final regulations that adopt the employer identifier were published in May 2002. The Final Rule adopts the Employer Identification Number (EIN), an existing identifier that has been issued by the Internal Revenue Service (IRS), as the unique identifier for employers for use in standard health care transactions. The use of this identifier improves the Medicare and Medicaid Programs and the effectiveness and efficiency of the health care industry in general by simplifying and enabling the efficient electronic transmission of certain health information.

The compliance date for the employer identifier standard was July 30, 2004, for all covered entities. For small health plans, the compliance date was August 1, 2005.

PROVIDER IDENTIFIER AND HEALTH PLAN IDENTIFIER

The National Provider Identifier (NPI) Final Rule adopting the HIPAA standard unique health identifier for health care providers was published in the Federal Register on January 23, 2004. Health care providers were encouraged to apply for an NPI as of the effective date of May 23, 2005. As of January 2006, the Medicare Program began to accept NPIs in electronic transactions; however the existing Medicare number must also be included with the claim. While health care providers were encouraged to apply for an NPI beginning on the effective date of this Final Rule, May 23, 2005, the Medicare Program is not yet accepting the NPI in standard transactions. All health care providers are eligible to be assigned NPIs. Once fully implemented, health care providers who are covered entities must obtain and use NPIs in all standard transactions and legacy identification numbers (e.g., UPIN, Medicaid Number) are not permitted. All HIPAA-covered entities must use NPIs by the compliance dates (May 23, 2007, for all covered entities except small health plans; May 23, 2008, for small health plans).

The standard unique identifier for health plans is currently under development by HHS.

PRIVACY STANDARDS

The *Standards for Privacy of Individually Identifiable Health Information* (Privacy Rule) establishes, for the first time, a set of national standards for the protection of medical records and other health information. HHS issued the Privacy Rule to implement HIPAA. The Privacy Rule standards address the use and disclosure of individuals' health information (i.e., PHI) by organizations subject to the Privacy Rule (called "covered entities"), as well as standards for individuals' privacy rights to understand and control how their health information is used. The HHS OCR is responsible for implementing and enforcing the HIPAA Privacy Rule.

HIPAA Privacy Rule

Further guidance on the HIPAA Privacy Rule can be found at *www.hhs.gov/ocr/hipaa/privrulepd.pdf* on the CMS website.

HIPAA Privacy Rule Implementation

Information on CMS implementation of the HIPAA Privacy Rule for the Medicare Program may be found at *www.cms.hhs.gov/HIPAAGenInfo/Downloads/Implementation.pdf* on the CMS website.

A major purpose of the Privacy Rule is to define and limit the circumstances in which an individual's PHI may be used or disclosed by covered entities. A covered entity may not use or disclose PHI, except either:

- As the Privacy Rule permits or requires
- As the subject of the information (or the individual's personal representative) authorizes in writing

A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being. The Privacy Rule strikes a balance that permits important uses of information while protecting the privacy of individuals who seek care and healing. Given that the health care marketplace is diverse, the Privacy Rule is designed to be flexible, comprehensive, and to cover the variety of uses and disclosures that need to be addressed.

WHAT INFORMATION IS PROTECTED?

The Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information PHI.

Individually identifiable health information is information, including demographic data, that relates to the:

- Individual's past, present, or future physical or mental health or condition
- Provision of health care to the individual
- Past, present, or future payment for the provision of health care to the individual
- Identification of the individual (or for which there is a reasonable basis to believe that information can be used to identify the individual)

Individually identifiable health information includes many common identifiers such as name, address, birth date, and Social Security Number (SSN).

De-Identified Health Information

There are no restrictions on the use or disclosure of de-identified health information. De-identified health information neither identifies nor provides a reasonable basis to identify an individual. There are two ways to de-identify information:

1. Use a formal determination by a qualified statistician.

2. Remove specified identifiers of the individual and of the individual's relatives, household members, and employers. This is required and considered adequate only if the covered entity has no actual knowledge that the remaining information could be used to identify the individual.

PRIVACY REQUIREMENTS FOR HEALTH CARE PROVIDERS

Every health care provider, regardless of size, who electronically transmits health information in connection with certain transactions, is a covered entity. These transactions include claims, benefit eligibility inquiries, referral authorization requests, or other transactions for which HHS has established standards under the HIPAA Transactions Final Rule. Using electronic technology such as e-mail does not mean a health care provider is a covered entity; the transmission must be in connection with a standard transaction.

The Privacy Rule covers a health care provider whether it electronically transmits these transactions directly or uses a billing service or other third party to do so on its behalf. Health care providers include all providers of services (e.g., institutional providers such as hospitals) and providers of medical or health services (e.g., non-institutional providers such as physicians, dentists, and other practitioners) as defined by Medicare and any other person or organization that furnishes, bills, or is paid for health care.

The privacy compliance date for all covered entities was April 14, 2003, except for small health plans that were required to be in compliance by April 14, 2004. The Privacy Rule excludes from PHI, employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. Section 1232g.

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

A covered entity must disclose PHI in only two situations:

1. Disclose to individuals (or their personal representatives) specifically when they request access to, or an accounting of disclosures of, their PHI.
2. Disclose to HHS when it is undertaking a compliance investigation, review, or enforcement action.

Permitted Uses and Disclosures

A covered entity is permitted, but not required, to use and disclose PHI without an individual's authorization for the following purposes or situations:

- To the individual (unless required for access or accounting of disclosures)
- Treatment, payment, and health care operations
- Opportunity to agree or object
- Incident to an otherwise permitted use and disclosure
- Public interest and benefit activities
- Limited data set for the purposes of research, public health, or health care operations

Covered entities may rely on professional ethics and best judgment in deciding which of these permissive uses and disclosures to make.

Authorization Uses and Disclosures

Except as otherwise permitted or required, a covered entity may not disclose PHI without a valid authorization. A covered entity may not condition treatment, payment, enrollment, or benefits eligibility on an individual granting an authorization, except in limited circumstances.

An authorization must be written in specific terms and may allow use and disclosure of PHI by the covered entity seeking the authorization or by a third party. Examples of disclosures that would require an individual's authorization include disclosures to a life insurer for coverage purposes, disclosures to an employer of the results of a pre-employment physical or laboratory test, or disclosures to a pharmaceutical firm for its own marketing purposes.

All authorizations must be in plain language and contain specific information regarding the information to be disclosed or used, the person(s) disclosing and receiving the information, expiration date, right to revoke in writing, and other data. The Privacy Rule contains transition provisions applicable to authorizations and other express legal permissions obtained prior to April 14, 2003.

Disclosure of Psychotherapy Notes

A covered entity must obtain an individual's authorization to use or disclose psychotherapy notes with the following exceptions:

- The covered entity who originated the notes may use the notes for treatment.
- A covered entity may use or disclose, without an individual's authorization, for its own training, and to defend itself in legal proceedings brought by the individual; for HHS to investigate or determine the covered entity's compliance with the Privacy Rule; to avert a serious and imminent threat to public health or safety; to a health oversight agency for lawful oversight of the originator of the psychotherapy notes; or for the lawful activities of a coroner or medical examiner, or as required by law.

In June 2004, CMS updated and outlined its guidance to substance abuse programs on how to properly treat PHI. Substance abuse treatment programs must not disclose information unless they can obtain consent or point to an exception to the Privacy Rule that specifically permits the disclosure. Programs must then make sure that the disclosure is also permissible under the Privacy Rule.

HIPAA Impact on Abuse Treatment Programs

For further information about how HIPAA impacts alcohol and drug abuse treatment programs, please visit *www.hipaa.samhsa.gov/part2comparisoncleared.htm* on the Web.

Disclosure of Health Information for Marketing Purposes

Marketing is any communication about a product or service that encourages recipients to purchase or use the product or service. The Privacy Rule carves out the following health-related disclosure activities from this definition of marketing:

- Communications to describe health-related products or services, or payment for them, provided by or included in a benefit plan of the covered entity making the communication
- Communications about participating providers in a provider or health plan network, replacement of or enhancements to a health plan, and health-related products or services available only to a health plan's enrollees that add value to, but are not part of, the benefits plan
- Communications for treatment of the individual
- Communications for case management or care coordination for the individual or to direct or recommend alternative treatments, therapies, health care providers, or care settings to the individual

Marketing also is an arrangement between a covered entity and any other entity whereby the covered entity discloses PHI, in exchange for direct or indirect remuneration, for the other entity

to communicate about its own products or services encouraging the use or purchase of those products or services.

A covered entity must obtain an authorization to use or disclose PHI for marketing, except for face-to-face marketing communications between a covered entity and an individual, and for a covered entity's provision of promotional gifts of nominal value. However, no authorization is needed to make a communication that falls within one of the exceptions to the marketing definition. An authorization for marketing that involves the covered entity's receipt of direct or indirect remuneration from a third party must reveal that fact.

Limiting Use and Disclosure to the Minimum Necessary

A central aspect of the Privacy Rule is the principle of minimum necessary use and disclosure. A covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of PHI needed to accomplish the intended purpose of the use, disclosure, or request. A covered entity must develop and implement policies and procedures to reasonably limit uses and disclosures to the minimum necessary. When the minimum necessary standard applies to a use or disclosure, a covered entity may not use, disclose, or request the entire medical record for a particular purpose, unless it can specifically justify the whole record as the amount reasonably needed for the purpose.

The minimum necessary requirement is not imposed in any of the following circumstances:

- Disclosure to, or a request by, a health care provider for treatment
- Disclosure to an individual who is the subject of the information or the individual's personal representative
- Use or disclosure made pursuant to an authorization
- Disclosure to HHS for complaint investigation, compliance review, or enforcement
- Use or disclosure that is required by law
- Use or disclosure required for compliance with the HIPAA Transactions Rule or other HIPAA Administrative Simplification Rules

Restricting Access and Use

For internal uses, a covered entity must develop and implement policies and procedures that restrict access and uses of PHI based on the specific roles of the members of its workforce. These policies and procedures must identify the individuals, or classes of individuals, in the workforce who need access to PHI to carry out their duties, the categories of PHI to which access is needed, and any conditions under which they need the information to do their jobs.

Limiting Disclosure Information

A covered entity must establish and implement policies and procedures (which may be standard protocols) for *routine recurring disclosures* or *requests for disclosures* that limit the PHI disclosed to that which is the minimum amount reasonably necessary to achieve the purpose of the disclosure. Individual review of each disclosure is not required. For non-routine, non-recurring disclosures, or requests for disclosures that it makes, a covered entity must develop criteria designed to limit disclosures to the information reasonably necessary to accomplish the purpose of the disclosure and review each of these requests individually in accordance with the established criteria.

Reasonable Reliance Standard

If another covered entity makes a request for PHI, a covered entity may rely, if reasonable under the circumstances, on the request as complying with this minimum necessary standard. Similarly, a covered entity may rely

upon requests as being the minimum necessary PHI from:

- A public official
- A professional (such as an attorney or accountant) who is the covered entity's business associate, seeking the information to provide services to or for the covered entity
- A researcher who provides the documentation or representation required by the Privacy Rule for research

Privacy Practices Notice and Other Individual Rights

Each covered entity, with certain exceptions, must provide a Privacy Practices Notice. The Privacy Rule requires that the notice contain certain elements to include:

- A description of the ways in which the covered entity may use and disclose PHI
- A description of the covered entity's duties to protect privacy, to provide the notice of privacy practices, and to abide by the terms of the current notice
- A description of the individual's rights, including the right to submit complaints to HHS and to the covered entity if he or she believes his or her privacy rights have been violated
- A point of contact for further information and for making complaints to the covered entity (covered entities must act in accordance with their notices)
- Specific distribution requirements for direct treatment providers, all other health care providers, and health plans

Privacy Practice Notice Distribution

As of April 14, 2003, any covered health care provider having a *direct treatment relationship* with patients must provide a Privacy Practices Notice to each patient as follows:

- Not later than the first service encounter by personal delivery (for patient visits), by automatic and contemporaneous electronic response (for electronic service delivery), and by prompt mailing (for telephonic service delivery)
- By posting the notice at each service delivery site in a clear and prominent place where people seeking service may reasonably be expected to be able to read the notice
- In emergency treatment situations, the provider must furnish its notice as soon as practicable after the emergency abates

Covered entities, whether *direct treatment providers*, *indirect treatment providers* (such as laboratories), or *health plans* must supply notice to anyone on request. A covered entity must also make its notice electronically available on any website it maintains for customer service or benefits information.

Acknowledgement of Notice Receipt

A covered health care provider with a *direct treatment relationship* with individuals must make a good faith effort to obtain written acknowledgement from patients of receipt of the Privacy Practices Notice. The Privacy Rule does not prescribe any particular content for the acknowledgement. The provider must document the reason for any failure to obtain the patient's written acknowledgement. The provider is relieved of the need to request acknowledgement in an emergency treatment situation.

Individual Access to Health Information

Except in certain circumstances, individuals have the right to review and obtain a copy of his or her PHI in a covered entity's designated record set. The designated record set is that group of records maintained by or for a covered entity. This record set is used, in whole or part, to make decisions about individuals. For providers, it may also serve as medical and billing records about individuals. For a health plan, it may serve as

enrollment, payment, claims adjudication, and case or medical management record systems.

The Privacy Rule makes exceptions from the right of access for the following PHI:

- Psychotherapy notes
- Information compiled for legal proceedings
- Laboratory results to which the Clinical Laboratory Improvement Amendments (CLIA) prohibits access
- Information held by certain research laboratories

For information included within the right of access, covered entities may deny access to an individual in certain specified situations, such as when a health care professional believes access could cause harm to the individual or another. In such situations, the individual must be given the right to have such denials reviewed by a licensed health care professional for a second opinion. Covered entities may impose reasonable, cost-based fees for the cost of copying and postage.

Accounting of Health Information Disclosure

Individuals have a right to an accounting of the disclosures of their PHI by a covered entity or the covered entity's business associates. The maximum disclosure accounting period is the 6 years immediately preceding the accounting request, except that a covered entity is not obligated to account for any disclosure made before the Privacy Rule compliance date.

The Privacy Rule does not require accounting for disclosures in the following instances:

- For treatment, payment, or health care operations
- To the individual or the individual's personal representative
- For notification of or to persons involved in an individual's health care or payment for health care, for disaster relief, or for facility directories
- Pursuant to an authorization
- Of a limited data set
- For national security or intelligence purposes
- To correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody
- Incident to otherwise permitted or required uses or disclosures

Accounting for disclosures to health oversight agencies and law enforcement officials must be temporarily suspended on its written representation that an accounting would likely impede its activities.

Restriction Request

Individuals have the right to request that a covered entity restrict use or disclosure of PHI for treatment, payment or health care operations; disclosure to individuals involved in the patient's health care or payment for health care; or disclosure to notify family members or others about the patient's general condition, location, or death. A covered entity is under no obligation to agree to requests for restrictions. A covered entity that does agree must comply with the agreed restrictions, except for purposes of treating the patient in a medical emergency.

Amendment of Protected Health Information (PHI)

The Privacy Rule gives individuals the right to have covered entities amend their PHI in a designated record set when that information is inaccurate or incomplete. If a covered entity accepts an amendment request, the covered entity must make reasonable efforts to provide the amendment to individuals identified as needing the amendment and to individuals that the covered entity knows might rely on the information to the individual's detriment. If the request is denied, covered entities must provide the individual with a written denial and allow the individual to submit a statement of disagreement

for inclusion in the record. The Privacy Rule specifies processes for requesting and responding to a request for amendment. A covered entity must amend PHI in its designated record set upon receipt of notice to amend from another covered entity.

Confidential Communications Requirements

Health plans and covered health care providers must permit individuals to request an alternative means or location for receiving communications of PHI by means other than those that the covered entity typically employs. For example, an individual may request that the provider communicate with the individual through a designated address or phone number. Similarly, an individual may request that the provider send communications in a sealed envelope rather than a postcard.

Health plans must accommodate reasonable requests if the individual indicates that the disclosure of all or part of the PHI could endanger the individual. The health plan may not question the individual's statement of endangerment. Any covered entity may condition compliance with a confidential communication request on the individual specifying an alternative address or method of contact and explaining how any payment will be handled.

ADMINISTRATIVE REQUIREMENTS FOR IMPLEMENTING HIPAA STANDARDS

In implementing HIPAA standards, a covered entity must fulfill many requirements in its organization and policies. These requirements are set in place to ensure that HIPAA standards are maintained while the information remains protected.

Privacy Policies and Procedures

A covered entity must develop and implement written privacy policies and procedures that are consistent with the Privacy Rule.

Privacy Policy Compliance Information

For additional information on complying with privacy policies and procedures, contact HIPAA directly at *www.cms.hhs.gov/HIPAAGenInfo/04_PrivacyStandards.asp* on the CMS website or by phone at 1-866-282-0659 (TTY/TDD users should call 1-877-326-1166).

Privacy Personnel

A covered entity must designate a privacy officer responsible for developing and implementing its privacy policies and procedures, and a contact person or contact office responsible for receiving complaints and providing individuals with information on the covered entity's privacy practices.

Workforce Training and Management

Workforce members include employees, volunteers, and trainees and may also include other individuals whose conduct is under the direct control of the entity (whether or not they are paid by the entity). A covered entity must train all workforce members on its privacy policies and procedures, as necessary and appropriate for them to carry out their functions. A covered entity must have and apply appropriate sanctions against workforce members who violate its privacy policies and procedures or the Privacy Rule.

Mitigation

A covered entity must mitigate, to the extent practicable, any harmful effect it learns was caused by use or disclosure of PHI by its workforce or its business associates in violation of its privacy policies and procedures or the Privacy Rule.

Data Safeguards

A covered entity must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent intentional or unintentional use or disclosure of PHI in violation of the Privacy Rule and to limit its incidental use and disclosure pursuant to otherwise permitted or required use or disclosure. Such safeguards might include shredding documents containing PHI before discarding them, securing medical records with lock and key or pass code, and limiting access to keys or pass codes.

Complaints

A covered entity must have procedures in place for individuals to complain about its compliance with its privacy policies and procedures and the Privacy Rule. The covered entity must explain those procedures in its Privacy Practices Notice.

Among other things, the covered entity must identify to whom individuals can submit complaints and provide advice that complaints can also be submitted to the Secretary of HHS.

Retaliation and Waiver

A covered entity may not retaliate against a person for exercising rights provided by the Privacy Rule, for assisting in an investigation by HHS or another appropriate authority, or for opposing an act or practice that the person believes in good faith violates the Privacy Rule. A covered entity may not require an individual to waive any right under the Privacy Rule as a condition for obtaining treatment, payment, and enrollment or benefits eligibility.

Documentation and Record Retention

A covered entity must maintain its privacy policies and procedures, its Privacy Practices Notices, disposition of complaints, and other actions, activities, and designations that the Privacy Rule requires to be documented. These documents and records must be maintained for the latter of 6 years after the date of its creation or the last effective date.

PROVISIONS

The Privacy Rule also addresses covered entities that fall under certain circumstances that require them to have a legal representative to act on their behalf.

Personal Representatives

The Privacy Rule requires a covered entity to treat a “personal representative” the same as the individual, with respect to uses and disclosures of the individual’s PHI, as well as the individual’s rights under the Privacy Rule. A personal representative is a person legally authorized to make health care decisions on an individual’s behalf or to act for a deceased individual or the estate. The Privacy Rule permits an exception when a covered entity has a reasonable belief that the personal representative may be abusing or neglecting the individual, or that treating the person as the personal representative could otherwise endanger the individual.

Special Case: Minors

In most cases, parents are the personal representatives for their minor children. Therefore, in most cases, parents can exercise individual rights, such as access to the medical record, on behalf of their minor children. In certain exceptional cases, the parent is not considered the personal representative. In these situations, the Privacy Rule defers to state and other law to determine the rights of parents to access and control the PHI of their minor children. If state and other law is silent concerning parental access to the minor’s PHI, a covered entity has discretion to provide or deny a parent access to the minor’s health information, provided the decision is made by a licensed health care professional in the exercise of professional judgment.

Law Enforcement and State-Designated Protection and Advocacy Systems

In July 2004, CMS clarified and outlined what amount of PHI should be provided to law enforcement officials by covered entities. The Privacy Rule is balanced to protect an individual's privacy while allowing important law enforcement functions to continue. The Rule permits covered entities to disclose PHI to law enforcement officials, without the individual's written authorization, under specific circumstances. Additionally, the Privacy Rule permits a covered entity to disclose PHI without the authorization of the individual to a state-designated Protection & Advocacy (P&A) System to the extent that disclosure is required by law. For more information about the Privacy Rule in relation to law enforcement and PSAs, please visit *www.hhs.gov/ocr/hipaa/* on the Web.

HOW DOES HIPAA ENFORCE STANDARDS?

Per the HIPAA Administration Simplification Enforcement Final Rule dated February 16, 2006, CMS has been designated by the Secretary of HHS to enforce all of the HIPAA administrative simplifications provisions. This includes transaction and code set standards, the security standards, unique identifier standards as they go into effect, and privacy standards.

CMS focuses on obtaining voluntary compliance and use a complaint-driven approach for enforcement of HIPAA's electronic transactions and code set provisions. When CMS receives a complaint about a covered entity, CMS notifies the entity in writing that a complaint has been filed. Following notification from CMS, the entity has the opportunity to:

1. Demonstrate compliance;
2. Document its good faith efforts to comply with the standards; and/or
3. Submit a corrective action plan.

Demonstrating Compliance - Covered entities are given an opportunity to demonstrate to CMS that they submitted compliant transactions.

Good Faith Policy - CMS' approach utilizes the flexibility granted in Title XI, Section 1176(b), of the Social Security Act to consider good faith efforts to comply when assessing individual complaints. Under Section 1176(b), HHS may not impose a Civil Monetary Penalty (CMP) where the failure to comply is based on reasonable cause, is not due to willful neglect, and the failure to comply is cured with a 30-day period. HHS has the authority under the statute to extend the period within which a covered entity may cure the non-compliance "based on the nature and extent of the failure to comply."

CMS recognizes that transactions often require the participation of two covered entities and that non-compliance by one covered entity may put the second covered entity in a difficult position. Therefore, during the period immediately following the compliance date, CMS intends to look at both covered entities' good faith efforts to come into compliance with the standards in determining, on a case-by-case basis, whether reasonable cause for the non-compliance exists and, if so, the extent to which the time for curing the non-compliance should be extended.

CMS does not impose CMPs on covered entities that deploy contingencies (to ensure the smooth flow of payments) if they have made reasonable and diligent efforts to become compliant and, in the case of health plans, to facilitate the compliance of their trading partners. Specifically, as long as a health plan can demonstrate to CMS its active outreach/testing efforts, the plan can continue processing payments to providers. In determining whether a good faith effort has been made, CMS places a strong emphasis on sustained actions and demonstrable progress.

Indications of good faith might include, for example, such factors as:

- Increased external testing with trading partners

- Lack of availability of, or refusal by, the trading partner(s) prior to October 16, 2003, to test the transaction(s) with the covered entity whose compliance is at issue
- In the case of a health plan, concerted efforts in advance of October 16, 2003, and continued efforts afterwards to conduct outreach and make testing opportunities available to its provider community

While there are many examples of complaints that CMS may receive, the following example illustrates how CMS expects the process to work.

Example:

A complaint is filed against an otherwise compliant health plan that accepts and processes both compliant and non-compliant transactions while working to help the plan's providers achieve compliance.

In this situation, CMS would:

1. Notify the plan of the complaint
2. Based on the plan's response to the notification, evaluate the plan's efforts to help its non-compliant providers come into compliance
3. If it is determined that the plan had demonstrated good faith and reasonable cause for its non-compliance, not impose a CMP for the period of time CMS determines is appropriate, based on the nature and extent of the failure to comply

For example, CMS would examine whether the health plan undertook a course of outreach actions to its trading partners on awareness and testing, with particular focus on the actions that occurred prior to October 16, 2003. Similarly, health care providers should be able to demonstrate that they took actions to become compliant prior to October 16, 2003. If CMS determines that reasonable and diligent efforts have been made, the cure period for non-compliance would be extended at the discretion of the federal government. Furthermore, CMS continues to monitor the covered entity to ensure that its sustained efforts bring progress towards compliance. If continued progress is not made, CMS steps up its enforcement efforts towards that covered entity.

Organizations that have exercised good faith efforts to correct problems and implement the changes required to comply with HIPAA should be prepared to document them in the event of a complaint being filed. This flexibility permits health plans to mitigate unintended adverse effects on covered entities' cash flow and business operations during the transition to the standards, as well as on the availability and quality of patient care.

HIPAA Standards Enforcement Information

Additional information on CMS' enforcement of HIPAA standards is available at *www.hhs.gov/ocr/combinedregtext.pdf* on the Web and *www.cms.hhs.gov/Enforcement/04_GeneralEnforcementInformation.asp* on the CMS website.

Additional information on HIPAA Administrative Simplification is available within the HIPAA Administrative Simplification Enforcement Final Rule available at *www.hhs.gov/ocr/hipaa/FinalEnforcementRule06.pdf* on the Web.

Corrective Action Plan (CAP) - After October 16, 2003, in addition to possible fines and CMPs imposed, CMS expects non-compliant covered entities to submit plans to achieve compliance in a manner and time acceptable to the Secretary.

NOTES

REFERENCE A: FORM CMS-1450 (UB-92)

COMPLETING AND FILING FORM CMS-1450

Important Notice Regarding Use of ICD-9-CM Diagnosis Codes

As of October 1, 2004, International Classification of Disease, 9th Revision, Clinical Modification (ICD-9-CM) Diagnosis Codes can no longer be used for **Hospital** outpatient claims submission. Hospital providers must instead use Healthcare Common Procedure Coding System (HCPCS) Codes, which includes the Current Procedural Terminology (CPT) Codes. For a full listing of HCPCS Codes, refer to *www.cms.hhs.gov/HCPCSReleaseCodeSets* on the Centers for Medicare & Medicaid Services (CMS) website.

Institutional providers such as hospitals, Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), and hospital-based clinics use Form CMS-1450 (also known as UB-92) to complete and submit a Medicare Part B claim to Medicare Fiscal Intermediaries (FIs). Examples of Part B claims submitted are outpatient hospital care such as laboratories, X-rays, or physical, occupational and speech therapy, as well as physical, occupational and speech therapy performed in a free-standing facility. In addition, ambulance services, flu and pneumococcal vaccines, and diagnostic services can also be billed as a Part B claim to the FI. Because Form CMS-1450 serves different kinds of providers, a particular provider may not need some of the data elements.

Electronic Portable Document Format (PDF) copies of Form CMS-1450 can also be downloaded from the Centers for Medicare & Medicaid Services (CMS) website at *www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp* on the CMS website. The PDF version of the form can be submitted electronically if the FI is utilizing Optical Character Recognition (OCR) equipment to accept and process the Form CMS-1450s.

Providers submitting paper claims should contact the appropriate FI before submitting these claims for payment. Some FIs may be able to accept a black and white copy of the CMS-1450. Other FIs may not accept a black and white copy if the FI is utilizing OCR equipment.

OCR is an automated scanning process similar to scanners that read price labels in grocery stores. OCR claims processing is faster and more accurate than systems requiring manual input. However, to work properly, OCR must accurately read and interpret the characters entered in each field. OCR can only read typed or machine-printed data that is electronically scanned into the system by the provider. Only an original, red-ink-on-white-paper Form CMS-1450 can be scanned and read by OCR. Black and white photocopies are not acceptable and will be returned. After the claims information is scanned using OCR, it is transmitted to the claims processing system, where it is validated and compared to other data until final processing occurs. To ensure accurate, quick claim processing, the following guidelines should be followed:

- Do not staple, clip, or tape anything to the Form CMS-1450 claim form.
- Place all necessary documentation in the envelope with the Form CMS-1450 claim form.
- Put the patient's name and Medicare number on each piece of documentation submitted
- Use dark ink.
- Use only upper-case (CAPITAL) letters.
- Use 10 or 12 pitch (pica) characters and standard dot matrix fonts.
- Do not use italics or script.
- Avoid using old or worn print bands or ribbons.
- Do not use dollar signs, decimals, or punctuation.
- Enter all information on the same horizontal plane within the designated field.
- Do not print, hand-write, or stamp any extraneous data on the form.
- Use only lift-off correction tape to make corrections.
- Ensure data is in the appropriate field and does not overlap into other fields.
- Remove pin-fed edges at side perforations.
- Use only an original red-ink-on-white-paper Form CMS-1450 claim form.

Visit *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website for the latest changes in CMS billing and coding requirements. Search for publication #100-04.

EXAMPLE FORM CMS-1450

An example of Form CMS-1450 is included on the following page.

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11

12 PATIENT NAME	13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a												A
b												B
												C

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT	
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b		.		.		.	b
c		.		.		.	c
d		.		.		.	d

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1						.	.		1
2						.	.		2
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	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR P AYMENTS	55 EST. AMOUNT DUE	56
A					.	.	
B					.	.	
C					.	.	
	57	DUE FROM PATIENT ▶			.	.	

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GR OUP NAME	62 INSURANCE GR OUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLO YER LOCATION	
A					A
B					B
C					C

67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
			A		B	
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	C		D		E	

	82 ATTENDING PHYS. ID	
a	83 OTHER PHYS. ID	a
b	A	b
a	OTHER PHYS. ID	a
b	B	b

	84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
a			
b			
c			
d		X	

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Form Locator (FL)	Information To Be Entered	Notes
FL 1 Untitled (Required)	Enter the name (line 1), mailing address (lines 2 and 3), and telephone number (line 4) of the provider submitting the claim.	At a minimum, enter the provider name, city, state, and Zip Code (in 5-digit or 9-digit format). A fax number may be entered in addition to the telephone number.
FL 2 Untitled (Optional)	Leave blank - not required by Medicare.	Discontinued effective October 16, 2003.
FL 3 Patient Control No. (Required)	Enter the patient's unique Patient Control Number (PCN) assigned by the provider to facilitate retrieval of individual financial records and posting of reimbursement information.	This number will be communicated back to providers on the financial Remittance Advice (RA) and other FI reports.
FL 4 Type of Bill (Required)	Enter the three-digit alphanumeric identification code to identify the type of facility, type of care, and the "frequency code" indicating the sequence of this bill during this particular episode of care.	1st digit = Facility type 2nd digit = Type of care provided 3rd digit = Billing sequence in this episode of care See Reference C for a full breakdown of the code structure by digit, and a list of Type of Bill Codes by Provider Number range(s).
FL 5 Federal Tax Number (Optional)	The number assigned by the federal government for tax report purposes.	Also known as a Tax Identification Number (TIN) or Employer Identification Number (EIN).
FL 6 Statement Covers Period (From - Through) (Required)	Enter the 6-digit beginning (From) and ending (Through) service dates for the period included on this bill in month, day, and year format (MMDDYY). The dates before the patient is entitled for coverage are not shown.	**Example:** "October 11, 1996" would be entered as "100196". Inpatient claims for un-reimbursed providers under the Prospective Payment System (PPS) may span to the provider's Fiscal Year End (FYE). With the exception of Home Health PPS claims, the statement covers period may not span two accounting years. The From date is used to determine a timely filing.

Form Locator (FL)	Information To Be Entered	Notes
FL 7 Covered Days (Required - Inpatient Only)	**Not required for Part B claims.**	
FL 8 Non-covered Days (Required for Inpatient)	**Not required for Part B claims.**	
FL 9 Coinsurance Days (Required for Inpatient)	**Not required for Part B claims.**	
FL 10 Lifetime Reserve Days (Required for Inpatient)	**Not required for Part B claims.**	
FL 11 Untitled (Optional)	Leave blank - not required by Medicare.	This is one of seven fields that have not been assigned for national use. Use of the field, if any, is assigned by the State Uniform Billing Committee (SUBC) and is uniform within a state.
FL 12 Patient Name (Required)	Enter the last name, first name, and middle initial (if any) of the patient.	The following guidelines should be followed unless the Medicare Health Insurance card dictates otherwise: ❖ No space should be left between a prefix and a name as in MacBeth, VonSchmidt, McEnroe. ❖ Titles (such as Sir, Msgr., Dr.) should not be recorded in this data element. ❖ Record hyphenated names with a hyphen as in Smith-Jones, Rebecca. ❖ To record the suffix of a name, write the last name, leave a space and write the suffix, then write the first name as in Snyder III, Harold, or Addams Jr., Glen.

Form Locator (FL)	Information To Be Entered	Notes
FL 13 Patient Address (Required)	Enter the patient's full mailing address including street number and name, Post Office (P.O.) Box or Rural Route (RR) number (if applicable), city name, state name, and Zip Code.	Use the standard state postal abbreviations and Zip Code instructions as defined for FL 1. A valid Zip Code is required for Peer Review Organization (PRO) purposes on inpatient bills.
FL 14 Patient Birth Date (Required)	Enter the patient's month, day, and year of birth in month, day, and year format (MMDDYYYY).	The birth year has been expanded to 4 digits to report the complete year of birth. **Example:** "June 27, 1902" should be entered as "06271902". If the birth date was not obtained after reasonable efforts by the provider, enter all zeroes into the field. **Example:** "00000000".
FL 15 Sex (Required)	Enter the sex of the patient as recorded at date of admission, outpatient service, or start of care.	Use the following codes to indicate the patient's sex: F = Female M = Male Use this entry in conjunction with diagnoses and surgical Procedure Code entries (see FLs 67-81) to identify inconsistencies.
FL 16 Marital Status (Optional)	Enter the marital status of the patient at date of admission, outpatient service, or home health request for anticipated payment (RAP). This information is not required for Medicare claims, but valid values under Health Insurance Portability and Accountability Act of 1996 (HIPAA) must be used when submitting this information.	Use the following HIPAA-accepted codes to indicate marital status: S = Single M = Married P = Life Partner X = Legally Separated D = Divorced W = Widowed U = Unknown

Form Locator (FL)	Information To Be Entered	Notes
FL 17 Admission Date (Required for Inpatient and Home Health)	**For hospital bill type 12X and SNF bill type 22X,** enter the date the patient was admitted to the provider for inpatient care in month, day, and year format (MMDDYY). **For a Home Health Agency (HHA),** enter the same date of admission that was submitted on the RAP for the episode in month, day, and year format (MMDDYY).	**Example:** "October 1, 1996", would be entered as "100196" for a hospital, or "10-01-96" for an HHA. When using the Form CMS-1450 as a hospice admission notice, the facility shows the date the beneficiary elected hospice care.
FL 18 Admission Hour (Optional)	**Not required for Part B claims.**	
FL 19 Type of Admission/Visit (Required for Inpatient)	**For hospital bill type 12X and SNF bill type 22X**, enter the code that indicates the priority for inpatient services.	Use the following Admission Codes: 1 = Emergency - the patient required immediate medical intervention as a result of severe, life-threatening, or potentially disabling conditions. Generally, the patient was admitted through the emergency room. 2 = Urgent - the patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available, suitable accommodation. 3 = Elective - the patient's condition permitted adequate time to schedule the availability of a suitable accommodation 4 = Newborn - use of this code necessitates the use of a Special Source of Admission Code(s)

Form Locator (FL)	Information To Be Entered	Notes
FL 19 Type of Admission/Visit (Required for Inpatient) (Con't)		5 = Trauma Center - visits to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or verified by the American College of Surgeons and involving a trauma activation 6-8 = Unassigned - do not use these codes 9 = Information Not Available - indicates that this information was unavailable for input
FL 20 Source of Admission (Required for Inpatient Hospital Admissions and Outpatient Registrations)	**For hospital bill type 12X and SNF bill type 22X,** enter the appropriate Source of Admission Code for hospital inpatient admissions and outpatient registrations.	Use the following Source of Admission Codes to indicate emergency, elective, or other type of admission: 1 = Physician Referral *Inpatient:* Patient was admitted to this facility based on recommendation of their personal physician. *Outpatient:* Patient was referred to this facility for outpatient or referenced diagnostic services by their personal physician, or the patient independently requested outpatient services (self-referral). 2 = Clinic Referral *Inpatient:* Patient was admitted to this facility upon recommendation of this facility's clinic physician. *Outpatient:* Patient was referred to this facility for outpatient or referenced diagnostic services by this facility's clinic or other outpatient department physician.

Form Locator (FL)	Information To Be Entered	Notes
FL 20 Source of Admission (Required for Inpatient Hospital Admissions and Outpatient Registrations) (Con't)		3 = HMO Referral *Inpatient:* Patient was admitted to this facility upon recommendation of an HMO physician. *Outpatient:* Patient was referred to this facility for outpatient or referenced diagnostic services by an HMO physician. 4 = Transfer from a Hospital (different facility*) *Inpatient:* Patient was admitted to this facility as a transfer from a different acute care facility where they were an inpatient. *Outpatient:* Patient was referred to this facility for outpatient or referenced diagnostic services by a physician of a different acute care facility. * For transfers from hospital inpatient in the same facility, see Code D. 5 = Transfer from a Skilled Nursing Facility (SNF) *Inpatient:* Patient was admitted to this facility as a transfer from an SNF where they were an inpatient. *Outpatient:* Patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the SNF where they are an inpatient. 6 = Transfer from another health care facility *Inpatient:* Patient was admitted to this facility from a health care facility other than an acute care facility or SNF. This includes transfers from nursing homes, long-term care facilities, and SNF patients that are at a non-skilled level of care.

Form Locator (FL)	Information To Be Entered	Notes
FL 20 Source of Admission (Required for Inpatient Admissions and Outpatient Registrations) (Con't)		*Outpatient:* Patient was referred to this facility for outpatient or reference diagnostic services by a physician of another health care facility where they are an inpatient. 7 = Emergency Room *Inpatient:* Patient was admitted to this facility upon the recommendation of this facility's emergency room physician. *Outpatient:* Patient received services in this facility's emergency department. 8 = Court/Law Enforcement *Inpatient:* Patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative. *Outpatient:* Patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services. 9 = Information Not Available *Inpatient:* The means by which the patient was admitted to this facility is not known. *Outpatient:* For Medicare outpatient bills, this is not a valid code. A = Transfer from a Critical Access Hospital (CAH) *Inpatient:* Patient was admitted to this facility as a transfer from a Critical Access Hospital (CAH) where they were an inpatient.

Form Locator (FL)	Information To Be Entered	Notes
FL 20 Source of Admission (Required for Inpatient Admissions and Outpatient Registrations) (Con't)		*Outpatient:* Patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) the CAH where the patient is an inpatient. B = Transfer from another HHA Patient was admitted to this HHA as a transfer from another HHA. C = Readmission to Same HHA Patient was readmitted to this HHA within the same home health episode period. D = Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer. E-Z = Reserved for National Assignment
FL 21 Discharge Hour (Optional)	**Not required for Part B claims.**	
FL 22 Patient Status (Required)	**For hospital bill type 12X and SNF bill type 22X,** enter the code that indicates a patient's status as of the Through date reported in the Statement Covers Period in FL 6.	The patient status code is required for all Part A inpatient, SNF, hospice, HHA, and outpatient hospital services. Use the following codes for Part A inpatient, SNF, hospice, HHA, and outpatient hospital services: 01 = Routine discharge to home or self care

Form Locator (FL)	Information To Be Entered	Notes
FL 22 Patient Status (Required) (Con't)		02 = Discharged/transferred to another short-term general hospital for inpatient care 03 = Discharged/transferred to SNF with Medicare certification in anticipation of covered skilled care (effective 2/23/2005) (See Code 61 below.) 04 = Discharged/transferred to an Intermediate Care Facility (ICF) 05 = Discharged/transferred to another type of institution not defined elsewhere in this code list (effective 2/23/2005) 06 = Discharged/transferred to home under care of organized home health care service organization in anticipation of covered skills care (effective 2/23/2005) 07 = Left against medical advice or discontinued care 08 = Discharged/transferred to home under care of a home IV drug therapy provider (discontinued effective 10/1/05) 09* = Admitted as inpatient to this hospital (after outpatient services) 20 = Expired (or did not recover - religious non-medical health care patient) 21-29 = Reserved for National Assignment 30 = Still a patient or expected to return for outpatient services 31-39 = Reserved for National Assignment

Form Locator (FL)	Information To Be Entered	Notes
FL 22 Patient Status (Required) (Con't)		40 = Expired at home (hospice claims only) 41 = Expired in a medical facility such as a hospital, SNF, ICF, or free-standing hospice (hospice claims only) 42 = Expired, place unknown (hospice claims only) 43 = Discharged/transferred to a government operated health care facility such as a Department of Defense (DOD) hospital, a Veterans Health Administration (VHA) hospital, or a VHA nursing facility. To be used whenever the destination at discharge is a federal health care facility whether the patient resides there or not.44-49 = Reserved for National Assignment 50 = Discharged/transferred to hospice - home 51 = Discharged/transferred to hospice - medical facility 52-60 = Reserved for National Assignment 61 = Discharged/transferred to a hospital-based Medicare-approved swing bed. 62 = Discharged/transferred to an Inpatient Rehabilitation Facility (IRF) including distinct part units of a hospital. 63 = Discharged/transferred to a Long Term Care Hospital (LTCH)

Form Locator (FL)	Information To Be Entered	Notes
FL 22 Patient Status (Required) (Con't)		64 = Discharged/transferred to a nursing facility certified under Medicaid, but not certified under Medicare65 = Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital (effective for discharges on or after April 1, 2004) 66 = Discharged/transferred to a Critical Access Hospital (CAH) (effective January 1, 2006) 67-70 = Reserved for National Assignment 71 = Discharged/transferred to another institution for outpatient services (discontinued effective October 1, 2003) 72 = Discharged/transferred to this institution for outpatient services (discontinued effective October 1, 2003) 73-99 = Reserved for National Assignment * In situations where a patient is admitted before midnight of the third day following the day of an outpatient diagnostic service or service related to the reason for the admission, the outpatient services are considered inpatient. Therefore, Code 09 would apply only to services that began longer than 3 days earlier or were unrelated to the reason for admission, such as observation following outpatient surgery, which results in admission.

Form Locator (FL)	Information To Be Entered	Notes
FL 23 Medical Record Number (Required)	Enter the number assigned by the provider to the patient's medical/health record.	Use the medical record number to audit the history of treatment. The FI must carry the medical record number through the FI system and return it to the provider. Do not substitute the medical record number for the PCN (see FL 3). However, the PCN may be the same number reported as the medical record number, and vice versa.
FLs 24-30 Condition Codes (Required)	Enter the appropriate code(s) used to identify conditions or events related to this billing period that may affect claim processing.	See Reference D for a full list of Condition Codes related to the bill that may affect processing.
FL 31 Untitled (Optional)	Unassigned - not required by Medicare.	Previously reserved for state use. Discontinued effective October 16, 2003.
FLs 32a-35a **FLs 32b-35b** Occurrence Code and Date (Required)	Enter the appropriate 2-digit Occurrence Code and associated 6-digit date in month, day, and year format (MMDDYY) to define a significant event relating to this bill that may affect claims processing.	Occurrence Codes have values ranging from 01 through 69, and A0 through L9. See Reference H for a full listing of Occurrence and Occurrence Span Codes. This form allows for interchangeable use of the FLs 32a-35b (Occurrence) and FLs 36a-36b (Occurrence Span) as necessary. If additional space is needed to enter all Occurrences, FLs 36a-36b (Occurrence Span) can be used for overflow Occurrence entries. Conversely, if more space is needed to enter Occurrence Span Codes, FLs 32a-35b (Occurrence) can be used for overflow Occurrence Span Code entries. When entering Occurrence Codes, complete FLs 32a-35b BEFORE using FLs 36a-36b for overflow codes.

Form Locator (FL)	Information To Be Entered	Notes
FL 36a-b Occurrence Span Code and Date	Enter the appropriate 2-digit Occurrence Code and associated “From and “Through” dates in 6-digit format (MMDDYY) to define a significant event relating to this bill that may affect claims processing.	Occurrence Span Codes and the associated dates used on outpatient (Part B) bills are 72, 74, 76, 77, M1 & M2. See Reference H for a full listing and definition of Occurrence Span Codes.
FL 37A-37C Internal Control Number (ICN)/Document Control Number (DCN) (Required)	When electronically submitting a previously processed claim, the ICN/DCN will automatically display in this field. When making claim adjustments to a paper claim that has been previously processed, providers should enter the control number assigned to the original bill.	Complete this field if making an adjustment request (Bill Type, FL 4 = XX7). Payer A’s ICN/DCN should be entered in line A of FL 37, Payer B’s on line B, and Payer C’s on line C, respectively.
FL 38 Untitled (Responsible Party Name and Address on Patient copy of bill) (Optional)	When Medicare is the secondary payer, the address of the primary payer may be shown here. For hospice claims only, the name, address and provider number of a transferring hospice is shown by the new hospice.	If the claim involves a payer of higher priority than Medicare, as defined in FL 58, the provider should enter the address of the other (primary) payer in FL 84 (Remarks).

Form Locator (FL)	Information To Be Entered	Notes
FLs 39-41 Value Codes and Amounts (Required)	Enter the value code and related dollar or unit amount(s) to identify data of a monetary nature that is necessary to process the claim. The code contains 2 alpha-numeric digits, and each value allows up to 9 numeric digits (0000000.00). Codes 50-53, 56-57, and 60-63 are not money amounts, but represent the numbers of visits.	Whole number or non-dollar amounts are right justified to the left of the dollar and cents delimiter. Some values are reported as cents, therefore the provider must refer to specific Value Codes for instructions. See Reference E for a full list of Value Codes. If more than one Value Code is entered for a billing period, codes are shown in ascending numeric order. There are four lines of data in order of A, B, C, and D. The provider should use each line sequentially (i.e., use FL 39a through 41a before using FLs 39b through 41b).
FL 42 Revenue Code (Required)	Enter the appropriate 4-digit numeric Revenue Code to explain specific ancillary charges. This code should be entered in FL 42 on the same line as the charge entered in FL 47 (the sum of charges billed) to which this code applies. For outpatient Part B billing, only charges believed to be covered are submitted in FL 47.	Revenue Codes should be listed in ascending numeric sequence to the extent possible. Revenue Code 0001 (Total Charges) should ALWAYS be the final Revenue Code entry. See Reference F for a full list of all applicable Revenue Codes.
FL 43 Revenue Description (Optional)	Enter the narrative description or standard abbreviation for each Revenue Code used in FL 42 on the line adjacent to the Revenue Code. This field is not applicable to electronic records.	HHAs identifying the specific piece of Durable Medical Equipment (DME) or non-routine supplies for which they are billing must use Healthcare Common Procedure Coding System (HCPCS) Codes in the description (also see FL 84). For a full listing of HCPCS Codes, refer to *www.cms.hhs.gov/HCPCSReleaseCodeSets* on the CMS website.

Form Locator (FL)	Information To Be Entered	Notes
FL 44 Healthcare Common Procedure Coding System (HCPCS)/ Rates (Required for Outpatient Services)	When coding HCPCS for outpatient services, enter the HCPCS Code describing the procedure.	For a full listing of HCPCS Codes, refer to *www.cms.hhs.gov/HCPCSReleaseCodeSets* on the CMS website. HCPCS coding must be reported for specific outpatient services. Examples include: ❖ Outpatient clinical diagnostic laboratory services billed to Medicare (enter the HCPCS Code describing the laboratory service) ❖ Outpatient hospital bills for Medicare-defined "surgery" procedure ❖ Outpatient hospital bills for outpatient partial hospitalization ❖ Radiology and other diagnostic services ❖ Orthotics, prosthetics, and take-home surgical dressings ❖ ESRD drugs, supplies, and laboratory services ❖ Medicare-covered preventative services (e.g., influenza or pneumococcal vaccines) ❖ Other provider services in accordance with CMS billing guidelines

Form Locator (FL)	Information To Be Entered	Notes
FL 45 Service Date (Required)	Community Mental Health Centers (CMHCs) and hospitals report line item dates of service wherever a HCPCS Code is required for services paid under the Outpatient Prospective Payment System (OPPS). This includes claims where the From and Through dates are equal. SNF providers must report line item dates of service when using HCPCS Codes on outpatient claims.	Exceptions: CAHs; Indian Health Services (IHS) hospitals, and hospitals located in American Samoa, Guam, and Saipan. For all outpatient claims, all line items must contain a date of service for each Revenue Code or the claim will be rejected. When a particular service is rendered more than once during the billing period, the revenue code and HCPCS code must be entered separately for each service date.
FL 46 Service Units (Required)	Generally, the entries in this column quantify services by revenue category or Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) Code. Up to 7 numeric digits may be entered. **If Revenue Codes are being used,** enter the number of units for each applicable service provided or the number of days that a particular accommodation was provided. **If HCPCS Codes are required for services,** enter the number of times the procedure/service being reported was performed. **If documenting a blood transfusion,** enter the number of pints of blood.	Providers should provide the number of covered days, visits, treatments, procedures, tests, etc., as applicable for the following: ❖ Accommodations - 0100s-0150s, 0200s, 0210s (days) ❖ Blood pints - 0380s (pints) ❖ DME - 0290s (rental months) ❖ Emergency room - 0450, 0452, and 0459 (HCPCS Code definition for visit or procedure) ❖ Clinic visits - 0510s and 0520s (HCPCS Code definition for visit or procedure) ❖ Dialysis treatments - 0800s (sessions or days) ❖ Orthotic/prosthetic devices - 0274 (items) ❖ Outpatient therapy visits - 0410, 0420, 0430, 0440, 0480, 0910, and 0943 (units are equal to the number of times the procedure/service being reported was performed)

Form Locator (FL)	Information To Be Entered	Notes
FL 46 Service Units (Required) (Con't)		❖ Outpatient clinical diagnostic laboratory tests - 030X-031X (tests) ❖ Radiology - 032x, 034x, 035x, 040x, 061x, and 0333 (HCPCS Code definition of tests or services) ❖ Oxygen - 0600s (rental months, feet, or pounds) ❖ Drugs and Biologicals - 0636 (including hemophilia clotting factors) Hospital outpatient departments report the number of visits/sessions when submitting claims under the partial hospitalization program. For Rural Health Clinics (RHCs) or Federally Qualified Health Centers (FQHCs), a "visit" is defined as a face-to-face encounter between a clinic/center patient, and one of the certified RHC or FQHC health professionals. Encounters with more than one health professional, and encounters with the same health professional which take place on the same day and at a single location constitute a single "visit", except for cases in which the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

Form Locator (FL)	Information To Be Entered	Notes
FL 46 Service Units (Required) (Con't)		EXAMPLE: A known diabetic visits the provider on the morning on May 1st and sees the Physician's Assistant (PA). The PA believes an adjustment in current medication is required, but wishes to have the clinic's physician, who will be present in the afternoon, check the determination. The patient returns in the afternoon and sees the physician, who revises the prescribed medication. The physician recommends that the patient return the following week, on May 8th, for a fasting blood sugar analysis to check the response to the change in medication. In this situation, the provider submits claims to the Medicare Program for one visit. Also, it includes a line item charge for laboratory services for May 1st.
FL 47 Total Charges (Required)	Enter the total charges for the billing period for each Revenue Code. This field is not applicable to electronic billers.	The last Revenue Code entered in FL 42 should be "0001", which represents the grand total of all charges billed. Each line for FL 47 allows up to nine numeric digits (0000000.00). Electronic billers must not submit a Revenue Center Code of 0001. For outpatient Part B billing, only charges believed to be covered are submitted in FL 47.Non-covered charges are omitted from the bill. Laboratory tests (Revenue Codes 0300-0319) are billed as net for outpatient or non-patient bills because payment is based on the lower of charges for the hospital component or the Fee Schedule.

Form Locator (FL)	Information To Be Entered	Notes
FL 47 Total Charges (Required) (Con't)		The FI, in consultation with the provider, determines whether the provider must bill net or gross for each revenue center other than laboratory. Where "gross" billing is used, the FI adjusts interim payment rates to exclude payment for hospital-based physician services. The physician component must be billed to the Carrier to obtain payment. All Revenue Codes requiring HCPCS Codes and paid under a Fee Schedule are billed as net.
FL 48 Non-covered Charges (Required)	If billing a Condition Code 20 or Part B Advanced Beneficiary Notice (ABN), this field would be used on a Part B claim.	
FL 49 Untitled (Optional)	**Unassigned - not required by Medicare.**	
FL 50 A, B, and C Payer Identification (Required)	**If Medicare is the primary payer,** enter "Medicare" on line A. **If Medicare is the secondary or tertiary payer,** enter the primary payer on line A and enter Medicare information on lines B (secondary) or C (tertiary), as appropriate.	Entering Medicare on line A indicates that the provider has developed for other insurance and determined that Medicare is the primary payer. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A. Conditional payments for Medicare Secondary Payer (MSP) situations will not be made based on an HHA Request for Anticipated Payment (RAP).
FL 51 A, B, and C Provider Number (Required)	Enter the 6-digit number assigned by Medicare on the same line as "Medicare" in FL 50.	The Provider Number must be entered on the same line as "Medicare" in FL 50.

Form Locator (FL)	Information To Be Entered	Notes
FL 52 A, B, and C Release of Information Certification Indicator (Required)	Enter the appropriate Release of Information Code on the line pertaining to Medicare's payer status: line A (primary); line B (secondary); or line C (tertiary).	The following codes should be used: Y = Provider has a signed statement on file permitting data release to other organizations to process the claim R = Release is limited or restricted N = No release on file The back of the CMS-1450 contains a certification statement used to indicate that all necessary release statements are on file.
FL 53 A, B, and C Assignment of Benefits Certification Indicator (Optional)	**Not required by Medicare.**	
FL 54 A, B, and C Prior Payments (Required)	For all services other than inpatient hospital or SNF, enter the sum of any amounts collected from the patient toward deductibles (cash deductible and blood deductible) and/or coinsurance are entered on the Due From Patient (fourth/last line) of this column on the line pertaining to Medicare's payer status: line A (primary); line B (secondary); or line C (tertiary).	In apportioning payments between cash and blood deductibles, the first 3 pints of blood are treated as non-covered by Medicare. Thus, for example, if total inpatient hospital charges were $350.00, including $50.00 for a deductible pint of blood, the hospital would apportion $300.00 to the Part A deductible and $50.00 to the blood deductible. Blood is treated the same way in both Part A and Part B. Part A home health DME cost sharing amounts collected from the patient are reported in this item.
FL 55 A, B, and C Estimated Amount Due (Optional)	Enter the estimated amount due for services on the line pertaining to Medicare's payer status: line A (primary); line B (secondary); or line C (tertiary).	
FL 56 Untitled (Optional)	Unassigned - not required by Medicare.	Previously reserved for state use. Discontinued effective October 16, 2003.

Form Locator (FL)	Information To Be Entered	Notes
FL 57 Untitled (Optional)	Unassigned - not required by Medicare.	Previously reserved for state use. Discontinued effective October 16, 2003.
FL 58 A, B, and C Insured's Name (Required)	On the same lettered line (A, B, C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, enter the patient's name as shown on his or her health insurance or Medicare Health Insurance card.	The name must be the same as on the patient's Medicare Health Insurance card or other Medicare notice. The entry may differ from the name the Medicare beneficiary uses in every day conversation and may have indicated within the provider records. For example, the beneficiary's Medicare Health Insurance card may say "James Smith", but the beneficiary may use a nickname of "Jim Smith" on a daily basis and within paperwork. The insured's name must correspond to the payer identification information in FLs 50-54. All additional entries across line A (FLs 59-66) pertain to the person named in FL 58A. The instructions that follow explain when to complete these FL entries. The provider must enter the name of the individual in whose name the insurance is carried if there are payer(s) of higher priority than Medicare and it is requesting payment because: ❖ Another payer paid some of the charges and Medicare is secondarily liable for the remainder ❖ Another payer denied the claim

Form Locator (FL)	Information To Be Entered	Notes
FL 58 A, B, and C Insured's Name (Required) (Con't)	On the same lettered line (A, B, C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, enter the patient's name as shown on his or her health insurance or Medicare Health Insurance card.	❖ The provider is requesting conditional payment. If that person is the patient, the provider enters "Patient". Payers of higher priority than Medicare include: ❖ Employee Group Health Plans (EGHPs) for employed beneficiaries and spouses age 65 or over ❖ EGHPs for beneficiaries entitled to benefits solely on the basis of ESRD during a period of up to l2 months ❖ Large Group Health Plans (LGHPs) for disabled beneficiaries ❖ An auto-medical, no-fault, or liability insurer ❖ Workers' Compensation (WC) including Black Lung
FL 59 A, B, and C Patient's Relationship to Insured (Required)	If claiming payment under any of the circumstances described under FLs 58 A, B, or C, enter the appropriate code to define the relationship of the patient to the insured: line A (primary); line B (secondary); or line C (tertiary).	See Reference G for a complete listing of Relationship Codes.
FL 60 A, B, and C Certificate/Social Security Number/Health Insurance Claim Identification Number (HICN) (Required)	Enter the patient's Medicare number on the line pertaining to Medicare's payer status as it corresponds to Medicare payer information entered in FLs 50-54: line A (primary); line B (secondary); or line C (tertiary).	If Medicare is the primary payer, enter this information in FL 60A. Enter the number as it appears on the patient's Medicare Health Insurance card, Certificate of Award, Medicare Summary Notice (MSN), or as reported by the Social Security Office.

Form Locator (FL)	Information To Be Entered	Notes
FL 60 A, B, and C Certificate/Social Security Number/Health Insurance Claim Identification Number (HICN) (Required) (Con't)		If the provider is reporting any other insurance coverage higher in priority than Medicare [e.g., EGHP for the patient or the patient's spouse or during the first year of End Stage Renal Disease (ESRD) entitlement], enter the involved claim number for that coverage on the appropriate line.
FL 61 A, B, and C Group Name (Required)	If claiming payment under the circumstances described in FL 58 and there is WC or EGHP involvement, enter the primary payer's insurance group or plan name: line A (primary); line B (secondary); or line C (tertiary).	The insurance group name is the name of the group or plan through which that insurance is provided.
FL 62 A, B, and C Insurance Group Number (Required)	If claiming payment under the circumstances described in FL 58A, B or C, enter the identification number, control number, or code assigned by the health insurance carrier.	The Group Number is the identification number, control number, or code assigned by that health insurance carrier to identify the group under which the insured individual is covered.
FL 63 Treatment Authorization Code (Required)	If Quality Improvement Organization (QIO) review is performed for outpatient pre-admission, pre-procedure, or inpatient preadmission, the authorization number is required for all approved admissions or services.	Report Health Maintenance Organization (HMO) Preauthorization Codes in this FL.
FL 64 Employment Status Code (Required)	Enter the appropriate code to indicate the insured's employment status: line A (primary); line B (secondary); or line C (tertiary).	Where claiming payment under the circumstances described in FLs 58A, B, or C, the provider enters one of the following codes: 1 = Employed Full-Time - Individual claimed full-time employment 2 = Employed Part-Time - Individual claimed part-time employment

Form Locator (FL)	Information To Be Entered	Notes
FL 64 Employment Status Code (Required) (Con't)		3 = Not Employed - Individual states that they are not employed full-time or part-time 4 = Self-employed - Self-explanatory 5 = Retired - Self-explanatory 6 = On Active Military Duty - Self-explanatory 7 - 8 = Reserved for National Assignment 9 = Unknown - Individual's employment status is unknown
FL 65 Employer Name (Required)	If claiming payment under circumstances described in FL 58 and there is WC or EGHP involvement, enter the name of the employer that provides health care coverage for the individual identified on the same line in FL 58.	
FL 66 Employer Location (Required)	If claiming payment under circumstances described in FL 58 and there is WC or EGHP involvement, enter the insured's employer's location: line A (primary); line B (secondary); or line C (tertiary).	A specific location is the city, plant, etc., in which the employer is located.
FL 67 Principal Diagnosis Code (Required)	**For hospital bill types 12X and SNF bill type 22X,** enter the full HCPCS/CPT Diagnosis Code to the highest level of specificity available for the principal diagnosis.	The principal diagnosis is the condition established after study to be chiefly responsible for this admission. Even though another diagnosis may be more severe than the principal diagnosis, the hospital should enter the principal diagnosis. The code must include all 5 digits, where applicable. When the proper code has fewer than 5 digits, the hospital may **not** fill with zeroes.

Form Locator (FL)	Information To Be Entered	Notes
FL 67 Principal Diagnosis Code (Required) (Con't)	**For all other outpatient bill types,** enter the full ICD-9-CM Diagnosis Code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67 of the bill. Report the diagnosis to its highest degree of certainty.	**Medicare will reject a claim that contains a diagnosis code that is not valid at the time of service.** If the patient is seen on an outpatient basis by a non-hospital provider for evaluation of a symptom (e.g., cough), for which a definitive diagnosis is not made, the symptom must be reported (786.2). If, during the course of the outpatient evaluation and treatment, a definitive diagnosis is made (e.g., acute bronchitis), the hospital must report the definitive diagnosis (466.0). When a patient arrives at the hospital for examination or testing without a referring diagnosis and cannot provide a complaint, symptom, or diagnosis, the hospital should report an HCPCS/CPT Diagnosis Code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82). Examples include: ❖ Routine general medical examination (V70.0) ❖ General medical examination without any working diagnosis or complaint, patient not sure if the examination is a routine checkup (V70.9) ❖ Examination of ears and hearing (V72.1) Diagnosis Codes are not required on non-patient claims for laboratory services where the hospital functions as an independent laboratory.

Form Locator (FL)	Information To Be Entered	Notes
FLs 68-75 Other Diagnoses Codes (Required - Inpatient and Outpatient)	**For hospital outpatient services,** enter the full HCPCS/CPT Diagnosis Codes in FLs 68-75 for up to eight other diagnoses that coexisted at the time of admission or developed subsequently in addition to the diagnosis reported in FL 67, and that had an effect on the treatment provided or the length of stay **For all other outpatient services,** enter the full HCPCS/CPT Diagnosis Codes in FLs 68-75 for up to eight other diagnoses that coexisted at the time of admission in addition to the diagnosis reported in FL 67.	**Medicare will reject a claim that contains a diagnosis code that is not valid at the time of service.** FL 68-75 may not duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis. If the principal diagnosis is duplicated, the FI will remove the duplicate diagnosis before the record is processed. The Medicare Code Editor (MCE) identifies situations where the principal diagnosis is duplicated.
FL 76 Admitting Diagnosis/Patient's Reason for Visit (Required for Bill Type 12X and 22X)	**For bill types 12X and 22X,** enter the appropriate diagnosis code. This was a mandatory field as of July 1, 2004. **For all other outpatient bill types,** this is not required unless an unscheduled outpatient visit is being billed.	**Medicare will reject a claim that contains a diagnosis code that is not valid at the time of service.** The admitting diagnosis is the condition identified by the physician at the time of the patient's admission that required hospitalization. This definition is not the same as that used for SNF admission.
FL 77 E-Code (Optional)	Enter an External Cause of Injury Code (E-Code) if it is applicable to the condition.	Claims containing an invalid E-Code will be rejected. Health care facilities are encouraged to complete this FL whenever there is a diagnosis of an injury, poison, or adverse effect. Completion of this FL is voluntary in Florida.

Form Locator (FL)	Information To Be Entered	Notes
FL 77 E-Code (Optional) (Con't)		The priorities for recording E-Codes are: 1. Principal diagnosis of an injury or poisoning 2. Other diagnosis of an injury, poisoning, or adverse effect directly related to the principal diagnosis 3. Other diagnosis with an external cause
FL 78 Untitled (Optional)	Unassigned - not required by Medicare.	This is one of four fields that have not been assigned for national use. Use of the field, if any, is assigned by the SUBC, and is uniform within a state.
FL 79 Procedure Coding Method Used (Optional)	Enter the procedure coding system being used.	
FL 80 Principal Procedure Code and Date (Required - Inpatient Only)	**Not required for outpatient Part B claims.**	
FL 81 Other Procedure Codes and Dates (Required - Inpatient Only)	**Not required for outpatient Part B claims.**	
FL 82 Attending/Requesting Physician ID (Required)	**For a hospital,** enter the Unique Physician Identification Number (UPIN) and name of the attending or referring physician expected to certify and re-certify the medical necessity of the services rendered and/or who has primary responsibility for the patient's Medicare and treatment using the following format: UPIN; two spaces; last name; one space; first name; one space; middle initial.	This requirement applies to outpatient and Part B bills with a From date of January 1, 1992, or later.

Form Locator (FL)	Information To Be Entered	Notes
FL 82 Attending/Requesting Physician ID (Required) (Con't)	**For outpatient and other Part B,** enter the UPIN and name of the physician that requested the surgery, therapy, diagnostic tests or other services. If the patient is self-referred (e.g., emergency room or clinic visit), the provider enters SLF000 in the first 6 positions, and does not enter a name. **For home health and hospice,** enter the UPIN and name of the physician that signs the home health or hospice plan of care. **For claims where the physician is not assigned a UPIN,** enter one of the following UPINs to report these physicians: ❖ INT000 for each intern; ❖ RES000 for each resident; ❖ PHS000 for Public Health Service physicians, including IHS; ❖ VAD000 for Veterans Health Administration (VHA) physicians; ❖ RET000 for retired physicians; ❖ SLF000 for providers to report that the patient is self-referred; or ❖ OTH000 for all other unspecified entities not included above.	All Medicare claims require UPINs, including cases where there is a different primary insurer involved. Obtain UPINs from the physician's rendering/ordering services. Not all physicians are assigned UPINs. Where the physician is an intern or resident, the number assignment may not be complete. Also, numbers are not assigned to physicians who limit their practice to the Public Health Service, VHA, or IHS. For hospital services, use the Uniform Hospital Discharge Data Set definition for attending physicians. A SLF code will be accepted except where the Revenue Code or HCPCS Code indicates that the service can be provided only as a result of physician referral. The SLF000 and OTH000 ID may be audited. If referrals originate from physician-directed facilities (e.g., rural health clinics), the hospital enters the UPIN of the physician responsible for supervising the practitioner that provided the medical care to the patient. If more than one referring physician is indicated, the provider enters the UPIN of the physician requesting the service with the highest charge. **All claims containing a UPIN of NPP000 will be rejected.** HIPAA mandated the adoption of a standard unique health identifier for health care providers. On January 23, 2004, a Final Rule was published that adopted the National Provider Identifier (NPI) as this identifier. For information regarding the implementation of the NPI, see *www.cms.hhs.gov/NationalProvidentStand/* on the CMS website.

Form Locator (FL)	Information To Be Entered	Notes
FL 83 Other Physician ID [Outpatient Hospital] (Required When Subject to ASC Payment)	**If the HCPCS Code is under Ambulatory Surgical Center (ASC) payment limitations, or a reported HCPCS Code is on the list of codes provided by the QIO requires approval,** enter the UPIN and name of the physician using the inpatient format listed above.	
FL 84 Remarks (Required)	For DME billings by HHAs, the provider must document the rental rate, cost, and anticipated months of usage so that the FI can determine whether to approve the rental or purchase of the equipment. **If DME was purchased and Medicare is secondary payer,** enter notations providing any additional information necessary to adjudicate the claim. **If DME was purchased and Medicare is the secondary payer to WC, automobile medical, no-fault, liability insurer, or an EGHP,** enter the address of the responsible payer if this information was not previously entered in FL 38.	Enter any remarks that provide information that is not reported elsewhere on the bill, but which may be necessary to ensure proper Medicare payment (e.g., explanation for adjustment or cancel bill). For Renal Dialysis Facilities (RDFs), enter the first month of the 30-month period during which Medicare benefits are secondary to benefits payable under an EGHP.
FL 85 Provider Representative Signature (Required on Hardcopy)	**If certification is required,** the provider representative must make sure that the required physician's certification and recertification(s) are in the records and sign the form.	A provider representative signature is required for psychiatric or tuberculosis (TB) hospital services. A stamped signature is acceptable.
FL 86 Date (Hardcopy Only)	**If certification is required,** enter the 8-digit date in month, day, and year format (MMDDYYYY) when the provider representative signed the form.	

REFERENCE B: FORM CMS-1450 (UB-92)

ELECTRONIC CLAIM FORMAT CROSSWALK

The Electronic Claim Format Item Crosswalk specifies both conditional and required standard data elements that serve as the minimal requirements for processing a Part B claim, depending on the provider type. This crosswalk relates Form CMS-1450 Form Locater (FL) items (hardcopy) to the electronic National Standard Format (NSF) and 837 format fields/records. This crosswalk is located at *www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp* on the CMS website.

The following codes indicate data element requirements within the crosswalk.

R = Required - MUST always be on a claim

C = Conditional - required on a claim if certain conditions exist

NR = Not Required - either optional or is not required to process a claim

* Includes qualifier if segment and element are repeated in the same loop

** Required only for hard copy

NOTE: This crosswalk documents the data elements that are required for a claim form to be submitted. If the data entered is incomplete or invalid, the claim will be returned as unprocessable.

This crosswalk does not specify field/record content or size. For this information, refer to the printing specifications that are included as part of the instructions for completing the Form CMS-1450, available in the *Medicare Claims Processing Manual* at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website. Search for publication #100-04. Highlighted fields within the crosswalk indicate locations of common Part B provider billing errors as described in Table 6-1 of this guide.

The following codes also apply to the crosswalk:

Code	Description
Hospital - I	Hospital - inpatient
Hospital - O	Hospital - outpatient
H	Hospice
C/OP	Comprehensive Outpatient Rehabilitation Facility (CORF)/Community Mental Health Center (CMHC)/Outpatient Physical Therapy
RH/FQ	Independent Rural Health Clinics/Free-standing Federally Qualified Health Centers
HH	Home Health Agency
RD	Renal Dialysis Facility (Non-hospital Operated)
Skilled Nursing Facility - I	Skilled Nursing Facility - inpatient
Skilled Nursing Facility - O	Skilled Nursing Facility - outpatient
RN	Religious Non-medical Health Care Institution

Additional data elements may be required by the *HIPAA X12N 837 Health Care Claim Implementation Guide*. For updates to this guide, please refer to *www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp* on the CMS website.

NOTE: The following crosswalk represents Medicare requirements only.

Paper FL	EMC Loop:Segment: Element*	Electronic Data Interchange (EDI) Data Element Description	Hospital							SNF		
			I	O	H	C/OP	RHC/ FQHC	HH	RD	I	O	RN
1	2010AA all segments	Provider Name, Address, Phone #	R	R	R	R	R	R	R	R	R	R
2	N/A	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
3	2300:CLM01	Patient Control Number	R	R	R	R	R	R	R	R	R	R
4	2300:CLM05	Type of Bill	R	R	R	R	R	R	R	R	R	R
5	2010AA:NM108	Federal Tax Number	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
6	2300:DTP03 :434 qualifier	Statement Covers Period (from-through)	R	R	R	R	R	R	R	R	R	R
7	2300:QTY01:CA qualifier	Covered Days	R	NR	NR	NR	NR	NR	NR	R	NR	R
8	2300:QTY01:NA qualifier	Non-covered Days	NR	NR	NR	NR	NR	NR	NR	R	NR	R
9	2300:QTY01:CD qualifier	Coinsurance Days	R	NR	NR	NR	NR	NR	NR	C	NR	C
10	2300:QTY01:LA qualifier	Lifetime Reserve Days (LRD)	R	NR	NR	NR	NR	NR	NR	C	NR	C
11	N/A	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
12	2010CA:NM103 :QC qualifier	Patient's Name	R	R	R	R	R	R	R	R	R	R
13	2010CA:N301	Patient's Address	R	R	R	R	R	R	R	R	R	R
14	2010CA:DMG02 :D8 qualifier	Patient's Birth date	R	R	R	R	R	R	R	R	R	R
15	2010CA:DMG03 :D8 qualifier	Patient's Sex	R	R	R	R	R	R	R	R	R	R
16	Not Used	Patient's Marital Status	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
17	2300:DTP03 :435 qualifier	Admission Date	R	NR	R	NR	NR	R	NR	R	NR	R
18	2300:DTP03 :435 qualifier	Admission Hour	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
19	2300:CL101	Type of Admission	R	NR	NR	NR	NR	NR	NR	R	NR	R
20	2300:CL102	Source of Admission	R	R	NR	NR	NR	R	NR	R	NR	R
21	2300:DTP03 :096 qualifier	Discharge Hour	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
22	2300:CL103	Patient Status	R	R	R	NR	NR	R	NR	R	R	R
23	2300:REF02:EA qualifier	Medical Record Number	C	C	C	C	C	C	C	C	C	C

Paper FL	EMC Loop:Segment: Element*	Electronic Data Interchange (EDI) Data Element Description	Hospital							SNF		
			I	O	H	C/OP	RHC/ FQHC	HH	RD	I	O	RN
24-30	2300:HI01:BG qualifier	Condition Codes	C	C	C	C	C	C	C	C	C	C
31	N/A	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
32-35	2300:HI01:BH	Occurrence Codes and Dates	C	C	C	C	C	C	C	C	C	C
36	2300:HI01:BI	Occurrence Span Codes and Dates	C	C	C	C	C	C	C	C	C	C
37	2300:REF02:F8 qualifier	Internal Control # (ICN)/Document Control # (DCN)	C	C	C	C	C	C	C	C	C	C
38	2300:REF02:EA qualifier	Responsible Party Names and Address	C	C	C	C	C	C	C	C	C	C
39-41	2300:H01:BE qualifier	Value Codes and Amounts	C	C	C	C	C	C	C	C	C	C
42	2400:SV201	Revenue Code	R	R	R	R	R	R	R	R	R	R
43	N/A	Revenue Description	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
44	2400:SV202	Healthcare Common Procedure Coding System (HCPCS)/ Health Insurance Prospective Payment System (HIPPS)/Rates	C	C	C	C	C	C	C	C	C	C
45	2400:DTP03	Service Date	NR	C	C	C	C	C	C	NR	C	C
46	2400:SV205	Service Units	R	R	R	R	R	R	R	R	R	R
47	2400:SV203	Total Charges	R	R	R	R	R	R	R	R	R	R
48	2400:SV207	Non-covered Charges	C	C	C	C	C	C	C	C	C	C
49	N/A	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
50	2010BC:NM103	Payer Identification	R	R	R	R	R	R	R	R	R	R
51	2010AA:REF01 :1A qualifier	Provider Number	R	R	R	R	R	R	R	R	R	R
52	2300:CLM09	Release of Information	R	R	R	R	R	R	R	R	R	R
53	2300:CLM08	Assignment of Benefits Certification Indicator	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
55	2300:AMT02:C5 qualifier	Estimated Amount Due	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
56	N/A	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
57	N/A	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR

Paper FL	EMC Loop:Segment: Element*	Electronic Data Interchange (EDI) Data Element Description	Hospital							SNF		
			I	O	H	C/OP	RHC/ FQHC	HH	RD	I	O	RN
58	2010AA:NM10 3IL qualifier	Insured's Name	R	R	R	R	R	R	R	R	R	R
59	2320:SBR02	Patient's Relationship to Insured	C	C	C	C	C	C	C	C	C	C
60	2010:NM109	Certificate/Social Security #/HI Claim #/Identification #	R	R	R	R	R	R	R	R	R	R
61	2320:SBR04	Group Name	C	C	C	C	C	C	C	C	C	C
62	2000:SBR02	Insurance Group Number	C	C	C	C	C	C	C	C	C	C
63	2300:REF02	Treatment Authorization Number	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
64	2320:SBR01	Employment Status Code	C	C	C	C	C	C	C	C	C	C
65	2320:SBR01	Employer Name	C	C	C	C	C	C	C	C	C	C
66	2320:SBR01	Employer Location	C	C	C	C	C	C	C	C	C	C
67	2300:HI01:BK qualifier	Principal Diagnosis Code	R	R	R	R	R	R	R	R	R	NR
68-75	2300:HI01:BF qualifier	Other Diagnosis Codes	C	C	C	C	C	C	C	C	C	NR
76	2300:HI02:BJ qualifier	Admitting Diagnosis	R	NR	NR	NR	NR	NR	NR	R	NR	NR
77	2300:HI03:BN qualifier	E-Code	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
78	N/A	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
79	N/A	Procedure Coding Method	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
80	2300:HI01:BP qualifier	Principal Procedure Code	C	NR	NR	NR	NR	NR	NR	NR	NR	NR
81	2300:HI01:BO qualifier	Other Procedure Codes and Dates	C	NR	NR	NR	NR	NR	NR	NR	NR	NR
82	2310A:NM101 :71 qualifier	Attending/Referring Physician I.D.	R	R	R	R	R	R	R	R	R	NR
83	2310B:NM103 :72	Other Physician I.D. (1)	C	C	C	C	C	NR	C	C	C	NR
83	2310B:NM103 :73	Other Physician I.D. (2)	C	C	C	C	C	NR	C	C	C	NR

Paper FL	EMC Loop:Segment: Element*	Electronic Data Interchange (EDI) Data Element Description	Hospital							SNF		
			I	O	H	C/OP	RHC/ FQHC	HH	RD	I	O	RN
84	2310C:N301	Remarks	C	C	C	C	C	C	C	C	C	C
85	N/A	**Provider Representative Signature	R	R	R	R	R	NR	R	R	R	R
86	N/A	**Date	R	R	R	R	R	NR	R	R	R	R

REFERENCE C: TYPE OF BILL (TOB) CODES

The Type of Bill (TOB) Code is a 3-digit alphanumeric code that provides three specific pieces of information. The first digit identifies the type of facility. The second digit classifies the type of care. The third digit indicates the sequence of the bill in a particular episode of care, also referred to as a frequency code. The TOB Code structure is broken down as described below.

1ST DIGIT INDICATES THE TYPE OF FACILITY:

1 Hospital

NOTE: Hospital-based multi-unit complexes may also have use for the following first digits when billing non-hospital services [e.g., hospital-based Skilled Nursing Facility (SNF)].

2 SNF

3 Home Health [Includes Home Health Agency (HHA) Prospective Payment System (PPS) claims where the Centers for Medicare & Medicaid Services (CMS) determines if payment should come from the Medicare Part A Trust Fund or the Medicare Part B Trust Fund.]

4 Religious non-medical (hospital)

5 Religious non-medical (extended care)

NOTE: As of October 1, 2005, bill type 5XX is no longer accepted and any claim containing this bill type will be returned to the provider.

6 Intermediate Care

7 Clinic or hospital-based Renal Dialysis Facility (RDF) (use requires special information in second digit below.)

8 Special Facility or Hospital Ambulatory Surgical Center (ASC) (use requires special information in second digit below.)

9 Reserved for National Assignment

2ND DIGIT CLASSIFICATION (IDENTIFIES THE TYPE OF CARE) IF FIRST DIGIT IS BETWEEN 1 AND 5:

1 Inpatient (Part A)

2 Hospital-Based or Inpatient (Part B) [For HHA non-PPS claims, this includes HHA visits under a Part B plan of treatment. For HHA PPS claims, this indicates a Request for Anticipated Payment (RAP).]

NOTE: For HHA PPS claims, CMS determines from which Medicare Trust Fund payment is made, therefore there is no need to indicate Part A or Part B on the claim.

3 Outpatient [For non-PPS HHAs, this includes HHA visits under a Part A plan of treatment and use of HHA Durable Medical Equipment (DME) also under a Part A plan of treatment.]

NOTE: For HHA PPS claims, CMS determines from which Medicare Trust Fund payment is made, therefore there is no need to indicate Part A or Part B on the claim.

4 Other (Part B) [Includes HHA medical and other health services not under a plan of treatment, hospital and SNF for diagnostic clinical laboratory services for "non-patients", and referenced diagnostic services. For HHAs under a PPS, this indicates an osteoporosis claim.]

NOTE: As of October 1, 2005, bill type 24X is no longer accepted and any claim containing this bill type will be returned to the provider. For services provided on or after April 1, 2006, bill type 14X should be used for billing of non-patient laboratory specimens. Fiscal Intermediaries (FIs) must also allow colorectal screening using HCSPCS codes G0107 and G0328 to be billed under 14X for non-patient laboratory specimens.

5 Intermediate Care - Level I

6 Intermediate Care - Level II

7 Subacute Inpatient (As of October 1, 2005, bill type X7X is no longer accepted and any claim containing this bill type will be returned to the provider.)

8 Swing Bed [May be used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement.]

9 Reserved for National Assignment

2ND DIGIT CLASSIFICATION(IF FIRST DIGIT IS 7):

1 Rural Health Clinic (RHC)

2 Hospital-Based or Independent RDF

3 Free-Standing Provider-Based Federally Qualified Health Center (FQHC)

4 Other Rehabilitation Facility (ORF)

5 Comprehensive Outpatient Rehabilitation Facility (CORF)

6 Community Mental Health Center (CMHC)

7-8 Reserved for National Assignment

9 OTHER

2ND DIGIT CLASSIFICATION (IF FIRST DIGIT IS 8):

1 Hospice (Non-hospital Based)

2 Hospice (Hospital Based)

3 ASC Services to Hospital Outpatients

4 Free-standing Birthing Center

5 Critical Access Hospital (CAH)

6-8 Reserved for National Assignment

9 OTHER

3RD DIGIT - FREQUENCY - IDENTIFIES THE BILLING SEQUENCE IN A PARTICULAR EPISODE OF CARE:

A Admission/Election Notice (Used when a hospice or religious non-medical health care institution is submitting Form CMS-1450 as an admission notice.)

B Hospice/Medicare Coordinated Care Demonstration/Religious Non-medical Health Care Institution Termination/Revocation Notice (Used when Form CMS-1450 is used as a notice of termination/revocation for a previously posted hospice/ Medicare coordinated care demonstration/religious non-medical health care institution election.)

C Hospice Change of Provider Notice (Used when Form CMS-1450 is used as a Notice of Change to the hospice provider.)

D Hospice/Medicare Coordinated Care Demonstration/Religious Non-medical Health Care Institution Void/Cancel (Used when Form CMS-1450 is used as a Notice of a Void/Cancel of Hospice, Medicare Coordinated Care Demonstration/Religious Non-medical Health Care Institution Election.)

E Hospice Change of Ownership (Used when Form CMS-1450 is used as a Notice of Change in Ownership for the hospice.)

F Beneficiary Initiated Adjustment Claim [Used to identify adjustments initiated by the beneficiary. For Fiscal Intermediary (FI) use only.]

G Common Working File (CWF) Initiated Adjustment Claim used to identify adjustments initiated by CWF. For FI use only.

H CMS Initiated Adjustment Claim [Used to identify adjustments initiated by CMS. For FI use only.]

I FI Adjustment Claim [other than Quality Improvement Organization (QIO) or provider. Used to identify adjustments initiated by the FI. For FI use only.]

J Initiated Adjustment Claim (Other) [Used to identify adjustments initiated by other entities. For FI use only.]

K Office of the Inspector General (OIG) Initiated Adjustment Claim [Used to identify adjustments initiated by OIG. For FI use only.]

M Medicare Secondary Payer (MSP) Initiated Adjustment Claim [Used to identify adjustments initiated by MSP. For FI use only.]

NOTE: MSP takes precedence over other adjustment sources.

P QIO Adjustment Claim [Used to identify an adjustment initiated as a result of a QIO review. For FI use only.]

0 Non-payment/Zero Claims (Provider uses this code when it does not anticipate payment from the payer for the bill, but is informing the payer about a period of non-payable confinement or termination of care. The Through date of this bill [Field Location (FL) 6] is the discharge date for this confinement or termination of care. Medicare requires “non-payment” bills only to extend the spell-of-illness in inpatient cases. Other non-payment bills are not needed and may be returned to the provider.)

1 Admit Through Discharge Claim [Provider uses this code for a bill encompassing an entire inpatient confinement or course of outpatient treatment for which the provider expects payment from the payer or which will update deductible for inpatient or Part B claims when Medicare is secondary to an Employer Group Health Plan (EGHP).]

2 Interim-First Claim (Used for the first of an expected series of bills for which utilization is chargeable or which will update inpatient deductible for the same confinement or course of treatment. For HHAs, this code is used for the submission of original or replacement RAPs.)

3 Interim-Continuing Claims (Used on a bill for which utilization is chargeable for the same confinement or course of treatment and bills had already been submitted and further bills are expected to be submitted later.)

4 Interim-Last Claim [Used for a bill for which utilization is chargeable and which is the last of a series for this confinement or course of treatment. The Through date of this bill [FL 6] is the discharge date for this confinement or course of treatment.]

5 Late Charge Only [Used for outpatient claims only. Late charges are not accepted for Medicare inpatient, home health, or ASC claims.]

7 Replacement of Prior Claim (Used by the provider to correct (other than late charges) a previously submitted bill. The provider applies this code to the corrected or “new” bill.)

8 Void/Cancel of a Prior Claim [The provider uses this code to indicate that a bill is an exact duplicate of an incorrect bill that was previously submitted. This code can be used by either the provider or the FI to cancel a paid claim. A Code 7 (Replacement of Prior Claim) is then usually submitted by the provider showing corrected information.]

9 Final Claim for an HHA PPS Episode (This code indicates the home health bill should be processed as a debit or credit adjustment to the request for anticipated payment.)

BILL TYPE CODES AND ALLOWABLE PROVIDER NUMBERS

The following table outlines which bill types are outpatient and which are inpatient.

Outpatient Bill Type	Facility Type
13X, 14X	Outpatient Hospital
23X, 24X	Skilled Nursing Facility (SNF)
32X, 33X, 34X	Home Health Agency (HHA)
71X	Rural Health Clinic (RHC)
72X	Renal Dialysis Facility (RDF)
73X	Federally Qualified Health Center (FQHC)
74X	Outpatient Rehabilitation Facility (ORF)
75X	Comprehensive Outpatient Rehabilitation Facility (CORF)
76X	Community Mental Health Center (CMHC)
81X, 82X	Hospice
83X	Hospice - Hospital Outpatient Surgery Subject to Ambulatory Surgical Center (ASC) Payment Limits
85X	Critical Access Hospital (CAH)
Inpatient Bill Type	**Facility Type**
11X	Hospital
12X	Inpatient Part B Hospital
18X	Swing Bed
21X	Skilled Nursing Facility (SNF)
22X	Inpatient Part B Skilled Nursing Facility (SNF)
41X	Religious Non-Medical Facility (RNHC)

For a definition of each facility type, refer to the *Medicare State Operations Manual* available at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website. Search for publication #100-07.

The following table lists “Type of Bill” [Field Locator (FL) 4] codes by Provider Number range(s). All outpatient bill types are highlighted.

Bill Type Code		Provider Number Range(s)
11X	Hospital Inpatient (Part A)	0001-0879, 1225-1299, 1300-1399, 2000-2499, 3025-3099, 3300-3399, 4000-4499, S001-S999, T001-T999
12X	Hospital Inpatient (Part B)	Same as 11X
13X	Hospital Outpatient	Same as 11X
14X	Hospital Other (Part B)	Same as 11X
18X	Hospital Swing Bed	U001-U999, W001-W999, Y001-Y999, Z001-Z999
21X	Skilled Nursing Facility (SNF) Inpatient	5000-6499
22X	Skilled Nursing Facility (SNF) Inpatient (Part B)	5000-6499
23X	Skilled Nursing Facility (SNF) Outpatient	5000-6499
28X	Skilled Nursing Facility (SNF) Swing Bed	5000-6499
32X	Home Health (visits under a Part B plan of treatment)	7000-7999, 8000-8499, 9000-9499, 9500-9799
33X	Home Health (visits under a Part A plan of treatment	7000-7999, 8000-8499, 9000-9499, 9500-9799
34X	Home Health (Part B Only)	7000-7999, 8000-8499, 9000-9499, 9500-9799
41X	Religious Non-medical Health Care Institutions	1990-1999
71X	Clinical Rural Health	3400-3499, 3975-3999, 8500-8999
72X	Clinic End Stage Renal Disease (ESRD)	2300-2399, 3500-3799
73X	Federally Qualified Health Centers (FQHCs)	1800-1989
74X	Clinic Outpatient Physical Therapy (OPT)	6500-6989
75X	Clinic Comprehensive Outpatient Rehabilitation Facility (CORF)	3200-3299, 4500-4599, 4800-4899
76X	Community Mental Health Centers (CMHCs)	1400-1499, 4600-4799, 4900-4999
81X	Non-hospital based hospice	1500-1799
82X	Hospital-based hospice	1500-1799
83X	Hospital Outpatient [Ambulatory Surgical Center (ASC)]	Same as 11X
85X	Critical Access Hospital (CAH)	1300-1399

REFERENCE D: CONDITION CODES

The following standard condition codes are approved by the Centers for Medicare & Medicaid Services (CMS) for use during Medicare claim completion.

Code	Title	Definition
02	Condition is Employment Related	Patient alleges that the medical condition causing this episode of care is due to environment/events resulting from the patient's employment.
03	Patient Covered by Insurance Not Reflected Here	Indicates that patient/patient representative has stated that coverage may exist beyond that reflected on this bill.
04	Information Only Bill	Indicates bill is submitted for informational purposes only. Examples would include a bill submitted as a utilization report, or a bill for a beneficiary who is enrolled in a risk-based managed care plan (such as the Medicare Advantage Plan) and the hospital expects to receive payment from the plan.
05	Lien Has Been Filed	The provider has filed legal claim for recovery of funds potentially due to a patient as a result of legal action initiated by or on behalf of a patient.
06	End Stage Renal Disease (ESRD) Patient in the First 30 Months of Entitlement Covered By Employer Group Health Plan (EGHP)	Medicare may be a secondary insurer if the patient is also covered by employer group health insurance during the patient's first 18 months of ESRD entitlement.
07	Treatment of Non-terminal Condition for Hospice Patient	The patient has elected hospice care, but the provider is not treating the patient for the terminal condition and is, therefore, requesting regular Medicare payment.
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage	Self-explanatory. The Fiscal Intermediary (FI) develops to determine proper payment.
09	Neither Patient Nor Spouse is Employed	In response to development questions, the patient and spouse have denied employment.

Code	Title	Definition
10	Patient and/or Spouse is Employed but no Employee Group Health Plan (EGHP) Coverage Exists	In response to development questions, the patient and/or spouse indicated that one or both are employed but have no group health insurance under an EGHP or other employer sponsored or provided health insurance that covers the patient.
11	Disabled Beneficiary But no Large Group Health Plan (LGHP)	In response to development questions, the disabled beneficiary and/or family member indicated that one or more are employed, but have no group coverage from an LGHP.
12-14	Payer Codes	Codes reserved for internal use only by third- party payers. The Centers for Medicare & Medicaid Services (CMS) will assign as needed for Fiscal Intermediary (FI) use. Providers will not report.
15	Clean Claim Delayed in Center for Medicare & Medicaid Service's (CMS's) Processing System (Medicare Payer Only Code)	The claim is a clean claim in which payment was delayed due to a CMS processing delay. Interest is applicable, but the claim is not subject to Clinical Practice Expert Panel (CPEP)/Current Procedural Terminology (CPT) standards.
16	Skilled Nursing Facility (SNF) Transition Exemption (Medicare Payer Only Code)	An exemption from the post-hospital requirement applies for this SNF stay or the qualifying stay dates are more than 30 days prior to the admission date.
17	Patient is Homeless	Self-explanatory.
18	Maiden Name Retained	A dependent spouse entitled to benefits that does not use her husband's last name.
19	Child Retains Mother's Name	A patient who is a dependent child entitled to benefits and he or she does not have the father's last name.
20	Beneficiary Requested Billing [Home Health and Inpatient Skilled Nursing Facility (SNF)]	Provider realizes services are non-covered level of care or excluded, but beneficiary requests determination by Medicare Contractor.
21	Billing for Denial Notice	The provider realizes services are at a non-covered level or excluded, but it is requesting a denial notice from Medicare to bill Medicaid or other insurers.

Code	Title	Definition
26	Veterans Health Administration (VHA) Eligible Patient Chooses to Receive Services In a Medicare Certified Facility	Patient is VHA-eligible and chooses to receive services in a Medicare-certified facility instead of a VHA facility.
27	Patient Referred to a Sole Community Hospital (SCH) for a Diagnostic Laboratory Test	The patient was referred for a diagnostic laboratory test. The provider uses this code to indicate laboratory service is paid at 62% Fee Schedule, rather than 60% Fee Schedule (SCHs only).
28	Patient and/or Spouse's Employee Group Health Plan (EGHP) is Secondary to Medicare	In response to development questions, the patient and/or spouse indicated that one or both are employed and that there is group health insurance from an EGHP or other employer-sponsored/provided health insurance that covers the patient but that either: (1) the EGHP is a single employer plan and the employer has fewer than 20 full and part time employees; or (2) the EGHP is a multi or multiple employer plan with fewer than 20 employees that elects to pay secondary to Medicare for employees and spouses aged 65 and older.
29	Disabled Beneficiary and/or Family Member's Large Group Health Plan (LGHP) is Secondary to Medicare	In response to development questions, the patient and/or family member(s) indicated that one or more are employed and there is group health insurance from an LGHP or other employer-sponsored/provided health insurance that covers the patient, but that either: (1) the LGHP is a single employer plan and the employer has fewer than 100 full and part-time employees; or (2) the LGHP is a multi or multiple employer plan and all employers participating in the plan have fewer than 100 full and part-time employees.
30	Qualifying Clinical Trials	Non-research services provided to all patients, including managed care enrollees, enrolled in a Qualified Clinical Trial.
31	Patient is a Student (Full-time, Day)	Patient declares that they are enrolled as a full-time day student.
32	Patient is a Student (Cooperative/Work Study Program)	Patient declares that they are enrolled in a cooperative/work study program.

Code	Title	Definition
33	Patient is a Student (Full-time, Night)	Patient declares that they are enrolled as a full-time night student.
34	Patient is a Student (Part-time)	Patient declares that they are enrolled as a part-time student.
35	Reserved for National Assignment	Self-explanatory.
36	General Care Patient in a Special Unit Not used by hospitals under the Prospective Payment System (PPS)]	**Not used on Part B claims.**
37	Ward Accommodation at Patient's Request [Not used by hospitals under the Prospective Payment System (PPS)]	**Not used on Part B claims.**
38	Semi-private Room Not Available [Not used by hospitals under the Prospective Payment System (PPS)]	**Not used on Part B claims.**
39	Private Room Medically Necessary [Not used by hospitals under the Prospective Payment System (PPS)]	**Not used on Part B claims.**
40	Same Day Transfer	**Not used on Part B claims.**
41	Partial Hospitalization	The claim is for partial hospitalization services. For outpatient services, this includes a variety of psychiatric programs (such as drug and alcohol).
42	Continuing Care Not Related to Inpatient Admission	Continuing care plan is not related to the condition or diagnosis for which the individual received inpatient hospital services.
43	Continuing Care Not Provided Within Prescribed Post Discharge Window	Continuing care plan was related to the inpatient admission but the prescribed care was not provided within the post discharge window.
44	Inpatient Admission Changed to Outpatient	For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its inpatient criteria. Effective April 1, 2004.
45	Reserved for National Assignment	Self-explanatory.

Code	Title	Definition
46	Non-Availability Statement on File	**Not used on Part B claims.**
47	Reserved for TRICARE	Reserved for TRICARE assignment.
48	Psychiatric Residential Treatment Centers (RTCs) for Children and Adolescents	**Not used on Part B claims.**
49	Product Replacement within Product Lifecycle	Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly.
50	Product Replacement for Known Recall of a Product	Manufacturer or FDA has identified the product for recall and therefore replacement.
51-54	Reserved for National Assignment	Self-explanatory.
55	Skilled Nursing Facility (SNF) Bed Not Available	**Not used on Part B claims.**
56	Medical Appropriateness	**Not used on Part B claims.**
57	Skilled Nursing Facility (SNF) Readmission	**Not used on Part B claims.**
58	Terminated Medicare Advantage Organization Enrollee	**Not used on Part B claims.**
59	Non-primary End Stage Renal Disease (ESRD) Facility	Used when a beneficiary receives non-scheduled or emergency dialysis services at a facility other than his or her primary ESRD facility.
60	Operating Cost Day Outlier	**Not used on Part B claims.**
61	Operating Cost Outlier (Not reported by providers, not used for capital cost outlier)	**Not used on Part B claims.**
62	Periodic Interim Payments (PIP) Bill (Not reported by providers)	Bill was paid under PIP. The Fiscal Intermediary (FI) records this from its system.
63	Payer Only Code	Reserved for internal payer use only. The Centers for Medicare & Medicaid Services (CMS) assigns as needed. Providers do not report this code. Indicates services rendered to a prisoner or a patient in state or local custody who meets the requirements of 42 CFR 411.4(b) for payment.

Code	Title	Definition
64	Other Than Clean Claim (Not reported by providers)	The claim is not “clean”. The Fiscal Intermediary (FI) records this from its system.
65	Non-Prospective Payment System (PPS) Bill (Not reported by providers)	Bill is not a PPS bill. The Fiscal Intermediary (FI) records this from its system for non-PPS hospital bills.
66	Hospital Does Not Wish Cost Outlier Payment (Used only by hospitals paid under PPS)	**Not used on Part B claims.**
67	Beneficiary Elects Not to Use Lifetime Reserve (LTR) Days	**Not used on Part B claims.**
68	Beneficiary Elects to Use Lifetime Reserve (LTR) Days	**Not used on Part B claims.**
69	Indirect Medical Education /Direct Graduate Medical Education/Nursing and Allied Health (IME/DGME/N&AH) Payment Only	**Not used on Part B claims.**
70	Self-Administered Epoetin (EPO)	The billing is for a home dialysis patient who self-administers EPO.
71	Full Care in Unit	The billing is for a patient who received staff-assisted dialysis services in a hospital or Renal Dialysis Facility (RDF).
72	Self-Care in Unit	The billing is for a patient who managed their own dialysis services without staff assistance in a hospital or Renal Dialysis Facility (RDF).
73	Self-Care Training	The bill is for special dialysis services where a patient and their helper (if necessary) were learning to perform dialysis.
74	Home	The bill is for a patient who received dialysis services at home.
75	Home 100-Percent	The bill is for a patient who received dialysis services at home using a dialysis machine that was purchased under the 100-Percent Program.
76	Back-up In-Facility Dialysis	The bill is for a home dialysis patient who received back-up dialysis in a facility.

Code	Title	Definition
77	Provider Accepts, is Obligated or Required because of a Contractual Arrangement or Law to Accept Payment as Payment in Full	The provider has accepted or is obligated/required to accept payment as payment in full due to a contractual arrangement or law. Therefore, no Medicare payment is due.
78	New Coverage Not Implemented by Health Maintenance Organization (HMO)	The bill is for a newly covered service under Medicare for which an HMO does not pay. (For outpatient bills, Condition Code 04 should be omitted.)
79	Comprehensive Outpatient Rehabilitative Facility (CORF) Services Provided Off-Site	Physical therapy, occupational therapy, or speech language pathology (SPL) services were provided off-site.
80	Home Dialysis-Nursing Facility	Home dialysis furnished in a SNF or Nursing Facility.
81-99	Reserved for State Assignment	Reserved for state assignment. Discontinued effective October 16, 2003.

REQUIRED SPECIAL PROGRAM INDICATOR CODES THAT APPLY TO MEDICARE

Code	Title	Definition
A0	Special Zip Code Reporting	Five-digit Zip Code of the location from which the beneficiary is initially placed on board the ambulance.
A3	Special Federal Funding	This code is for uniform use by State Uniform Billing Committees (SUBCs).
A5	Disability	This code is for uniform use by State Uniform Billing Committees (SUBCs).
A6	Medicare Pneumococcal Pneumonia Vaccine (PPV)/Influenza Vaccine 100% payment	Medicare pays under a special Medicare Program provision for pneumococcal pneumonia vaccine (PPV)/influenza vaccine services.
A7	Reserved for National Assignment	Discontinued October 1, 2002.
A8	Induced Abortion-Victim of Rape/Incest	Self-explanatory. Discontinued October 1, 2002.
A9	Second Opinion Surgery	Services requested to support second opinion in surgery. Part B deductible and coinsurance do not apply.
AA	Abortion Performed due to Rape	Self-explanatory. Effective October 1, 2002.
AB	Abortion Performed due to Incest	Self-explanatory. Effective October 1, 2002.
AC	Abortion Performed due to Serious Fetal Genetic Defect, Deformity, or Abnormality	Self-explanatory. Effective October 1, 2002.
AD	Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising From, or Exacerbated by the Pregnancy Itself	Self-explanatory. Effective October 1, 2002.
AE	Abortion Performed due to Physical Health of Mother that is not Life Endangering	Self-explanatory. Effective October 1, 2002.
AF	Abortion Performed due to Emotional/Psychological Health of the Mother	Self-explanatory. Effective October 1, 2002.
AG	Abortion Performed due to Social Economic Reasons	Self-explanatory. Effective October 1, 2002.
AH	Elective Abortion	Self-explanatory. Effective October 1, 2002.
AI	Sterilization	Self-explanatory. Effective October 1, 2002.

Code	Title	Definition
AJ	Payer Responsible for Copayment	Self-explanatory. Effective April 1, 2003.
AK	Air Ambulance Required	For ambulance claims. Air ambulance required - time needed to transport poses a threat. Effective October 16, 2003.
AL	Specialized Treatment/Bed Unavailable	For ambulance claims. Specialized treatment/bed unavailable so patient transported to an alternate facility. Effective October 16, 2003.
AM	Non-emergency Medically Necessary Stretcher Transport Required	Self-explanatory. Effective October 16, 2003.
AN	Preadmission Screening Not Required	Person meets the criteria for an exemption from pre-admission screening. Effective January 1, 2004.
AO-AZ	Reserved for National Assignment	Self-explanatory.
B0	Medicare Coordinated Care Demonstration Program	**Not used on Part B claims.**
B1	Beneficiary is Ineligible for Demonstration Program	**Not used on Part B claims.**
B2	Critical Access Hospital (CAH) Ambulance Attestation	Attestation by CAH that it meets the criteria for exemption from the Ambulance Fee Schedule.
B3	Pregnancy Indicator	Indicates patient is pregnant. Required when mandated by law. The determination of pregnancy should be completed in compliance with applicable law. Effective October 16, 2003.
B5-BZ	Reserved for National Assignment	Self-explanatory.
DR	Disaster Related	Used to identify disaster-related claims (effective August 21, 2005).
M0-M9	Payer Only Codes	Reserved for payer assignment.
MO	All-inclusive Rate for Outpatient Services	Used by a Critical Access Hospital (CAH) electing to be paid an all-inclusive rate for outpatient services.
M1	Roster Billed Influenza Virus Vaccine or Pneumococcal Pneumonia Vaccine (PPV)	Code indicates the influenza virus vaccine or PPV is being billed via the roster billing method by providers that mass immunize.

Code	Title	Definition
M2	Home Health Agency (HHA) Payment Significantly Exceeds Total Charges	Used when payment to an HHA is significantly in excess of covered billed charges.
D0	Changes to Service Dates	Self-explanatory.
D1	Changes to Charges	Self-explanatory.
D2	Changes to Revenue Codes/Healthcare Common Procedure Coding System (HCPCS)/ Health Insurance Prospective Payment System (HIPPS) Rate Code	Report this claim change reason code on a replacement claim [Field/Form Locator (FL) 4, Bill Type Frequency Code 7] to reflect a change in Revenue Codes (FL 42)/HCPCS/ Health Insurance Prospective Payment System (HIPPS) Rate Codes (FL 44).
D3	Second or Subsequent Interim Prospective Payment System (PPS) Bill	Self-explanatory.
D4	Changes in ICD-9-CM Diagnosis and/or Procedure Code	**Not used on Part B claims.**
D5	Cancel to Correct Health Insurance Claim Number (HICN) or Provider ID	Cancel only to delete an incorrect HICN or Provider ID Number.
D6	Cancel Only to Repay a Duplicate or Office of Inspector General (OIG) Overpayment	Cancel only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on an inpatient bill).
D7	Change to Make Medicare the Secondary Payer	Self-explanatory.
D8	Change to Make Medicare the Primary Payer	Self-explanatory.
D9	Any Other Change	Self-explanatory.
DA-DO	Reserved for National Assignment	Self-explanatory.
DR	Disaster Related	Used to identify claims that are or may be impacted by specific payer/health plan policies related to a national or regional disaster.
DS-DZ	Reserved for National Assignment	Self-explanatory.
E0	Change in Patient Status	Self-explanatory.
E1-FZ	Reserved for National Assignment	Self-explanatory.

Code	Title	Definition
G0	Distinct Medical Visit	Report this code when multiple medical visits occurred on the same day in the same revenue center. The visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day, in the morning for a broken arm and later for chest pain. Proper reporting of Condition Code G0 allows for payment under the Outpatient Prospective Payment System (OPPS) in this situation. The Outpatient Code Editor (OCE) contains an edit that will reject multiple medical visits on the same day with the same Revenue Code without the presence of Condition Code G0.
G1-GZ	Reserved for National Assignment	Self-explanatory.
H0	Delayed Filing, Statement of Intent Submitted	Indicates that Statement of Intent was submitted within the qualifying period to specifically identify the existence of another third-party liability situation.
M0	All Inclusive Rate for Outpatient Services (Payer Only)	Used by a Critical Access Hospital (CAH) electing to be paid an all-inclusive rate for outpatient.
N0-OZ	Reserved for National Assignment	Self-explanatory.
P0-PZ	Reserved for National Assignment FOR PUBLIC HEALTH DATA REPORTING ONLY	Self-explanatory.
Q0-VZ	Reserved for National Assignment	Self-explanatory. Discontinued effective February 23, 2005.
W0	United Mine Workers of America (UMWA) Demonstration Indicator	United Mine Workers of America (UMWA) Demonstration Indicator ONLY.
W1-ZZ	Reserved for National Assignment	Self-explanatory.

REFERENCE E: VALUE CODES AND AMOUNTS

The following value codes and amounts are approved for use in Field Locator (FL)/Block 39-41 of Form CMS-1450 (UB-92).

Code	Title	Definition
01	Most Common Semi-Private Rate	**Not used on Part B claims.**
02	Hospital Has No Semi-Private Rooms	**Not used on Part B claims.**
03	Reserved for National Assignment	Self-explanatory.
04	Inpatient Professional Component Charges Which Are Combined Billed (Used only by some all-inclusive rate hospitals)	**Not used on Part B claims.**
05	Professional Component Included in Charges and Also Billed Separately to Carrier (Part B Claims Only)	Indicates that the charges shown are included in billed charges in Field Locator (FL)/Block 47, but a separate billing for them will also be made to the Carrier. For outpatient claims, these charges are excluded in determining the deductible and coinsurance due from the patient to avoid duplication when the Carrier processes the bill for physician's services. These charges are also deducted when computing interim payment. The hospital also uses this code when outpatient treatment is for mental illness, and professional component charges are included in Field Locator (FL)/Block 47.
06	Medicare Part A and Part B Blood Deductible	The product of the number of unreplaced deductible pints of blood supplied times the charge per pint. If the charge per pint varies, the amount shown is the sum of the charges for each unreplaced pint furnished. If all deductible pints have been replaced, this code should not be used. When the hospital gives a discount for unreplaced deductible blood, it shows charges after the discount is applied.

Code	Title	Definition
07	Reserved for National Assignment	Self-explanatory.
08	Medicare Lifetime Reserve Amount in the First Calendar Year in Billing Period	**Not used on Part B claims.**
09	Medicare Coinsurance Amount in the First Calendar Year in Billing Period	The provider may not use this code on Part B bills. For Part B coinsurance, use value codes A2, B2, and C2.
10	Medicare Lifetime Reserve Amount in the Second Calendar Year in Billing Period	**Not used on Part B claims.**
11	Medicare Coinsurance Amount in the Second Calendar Year in Billing Period	The provider may not use this code on Part B bills.
12	Working Aged Beneficiary Spouse With an Employee Group Health Plan (EGHP)	That portion of a higher priority Employee Group Health Plan (EGHP) payment made on behalf of an aged beneficiary that the provider is applying to covered Medicare charges on this bill. Enter 6 zeros (0000.00) in the amount field to claim a conditional payment because the EGHP has denied coverage. When no payment or a reduced payment is received because of failure to file a proper claim, enter the amount that would have been payable had a proper claim been filed.
13	End Stage Renal Disease (ESRD) Beneficiary in a Medicare Coordination Period With an Employee Group Health Plan (EGHP)	That portion of a higher priority EGHP payment made on behalf of an ESRD priority beneficiary that the provider is applying to covered Medicare charges on the bill. Enter 6 zeros (0000.00) in the amount field if claiming a conditional payment because the EGHP has denied coverage. When no payment or a reduced payment is received because of failure to file a proper claim, enter the amount that would have been payable had a proper claim been filed.

Code	Title	Definition
14	No-Fault, Including Auto/Other Insurance	That portion of a higher priority no-fault insurance payment, including auto/other insurance, made on behalf of a Medicare beneficiary, that the provider is applying to covered Medicare charges on this bill. Enter 6 zeros (0000.00) in the amount field if claiming a conditional payment because the other insurer has denied coverage or there has been a substantial delay in payment. When receiving no payment or a reduced no-fault payment because of failure to file a proper claim, enter the amount that would have been payable had a proper claim been filed.
15	Workers' Compensation (WC)	That portion of a higher priority WC insurance payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. Enter 6 zeros (0000.00) in the amount field if claiming a conditional payment because there has been a substantial delay in payment. When receiving no payment or a reduced payment because of failure to file a proper claim, enter the amount that would have been payable had a proper claim been filed.
16	Public Health Service (PHS), Other Federal Agency	That portion of a higher priority PHS or other federal agency;s payment, made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges. **NOTE:** A 6-digit zero value entry (000000) for Value Codes 12-16 indicates that a conditional Medicare payment was requested.

Code	Title	Definition
17	Operating Outlier Amount (Not reported by providers)	The Fiscal Intermediary (FI) reports the amount of operating outlier payment made [either cost or day (day outliers have been obsolete since 1997)] in the Common Working File (CWF) with this code. No capital outlier payment should be included in this entry.
18	Operating Disproportionate Share Amount (Not reported by providers)	The Fiscal Intermediary (FI) reports the operating disproportionate share amount applicable. The FI uses the amount provided by the disproportionate share field in PRICER. The FI does not include any Prospective Payment System (PPS) capital Disproportionate Share Hospital (DSH) adjustment in this entry.
19	Operating Indirect Medical Education Amount (Not reported by providers)	The Fiscal Intermediary (FI) reports operating indirect medical education amount applicable. The FI uses the amount provided by the indirect medical education field in PRICER. The FI does not include any Prospective Payment System (PPS) capital Indirect Medical Education (IME) adjustment in this entry.
20	Payer Code (For internal use by third-party payers only)	
21	Catastrophic	Medicaid eligibility requirements to be determined at state level.
22	Surplus	Medicaid eligibility requirements to be determined at state level.
23	Recurring Monthly Income	Medicaid eligibility requirements to be determined at state level.
24	Medicaid Rate Code	Medicaid eligibility requirements to be determined at state level.
25	Offset to the Patient-Payment Amount - Prescription Drugs	Prescription drugs paid for out of a long-term care facility resident's funds in the billing period submitted (Field Locator (FL)/Block 6, Statement Covers Period).

Code	Title	Definition
26	Offset to the Patient-Payment Amount - Hearing and Ear Services	Hearing and ear services paid for out of a long-term care facility resident's funds in the billing period submitted (Field Locator (FL)/Block 6, Statement Covers Period).
27	Offset to the Patient-Payment Amount - Vision and Eye Services	Vision and eye services paid for out of a long-term care facility resident's funds in the billing period submitted. (Field Locator (FL)/Block 6, Statement Covers Period).
28	Offset to the Patient-Payment Amount - Dental Services	Dental services paid for out of a long-term care facility resident's funds in the billing period submitted (Field Locator (FL)/Block 6, Statement Covers Period).
29	Offset to the Patient-Payment Amount - Chiropractic Services	Chiropractic Services paid for out of a long-term care facility resident's funds in the billing period submitted (Field Locator (FL)/Block 6, Statement Covers Period).
31	Patient Liability Amount	The Fiscal Intermediary (FI) approved the provider charging the beneficiary the amount shown for non-covered accommodations, diagnostic procedures, or treatments.
32	Multiple Patient Ambulance Transport	If more than one patient is transported in a single ambulance trip, report the total number of patients transported.
33	Offset to the Patient-Payment Amount - Podiatric Services	Podiatric services paid for out of a long-term care facility resident's funds in the billing period submitted (Field Locator (FL)/Block 6, Statement Covers Period).
34	Offset to the Patient-Payment Amount - Other Medical Services	Other medical services paid for out of a long-term care facility resident's funds in the billing period submitted (Field Locator (FL)/Block 6, Statement Covers Period).
35	Offset to the Patient-Payment Amount - Health Insurance Premiums	Health insurance premiums paid for out of long-term care facility resident's funds in the billing period submitted (Field Locator (FL)/Block 6, Statement Covers Period).
36	Reserved for National Assignment	Self-explanatory.

Code	Title	Definition
37	Pints of Blood Furnished	The total number of pints of whole blood or units of packed red cells furnished, whether or not they were replaced. Blood is reported only in terms of complete pints rounded upwards (e.g., 1 1/4 pints is shown as 2 pints). This entry serves as a basis for counting pints towards the blood deductible.
38	Blood Deductible Pints	The number of **unreplaced** deductible pints of blood supplied. If all deductible pints furnished have been replaced, no entry is made.
39	Pints of Blood Replaced	The total number of pints of blood that were donated on the patient's behalf. Where one pint is donated, one pint is considered replaced. If arrangements have been made for replacement, pints are shown as replaced. Where the hospital charges only for the blood processing and administration (i.e., it does not charge a "replacement deposit fee" for unreplaced pints), the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 039X revenue code series (blood administration) or under the 030X revenue code series (laboratory).
40	New Coverage Not Implemented by Health Maintenance Organization (HMO) (Inpatient Services Only)	**Not used on Part B claims.**

Code	Title	Definition
41	Black Lung	That portion of a higher priority Black Lung payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. Enter 6 zeros (0000.00) in the amount field if claiming a conditional payment because there has been a substantial delay in payment. When receiving no payment or a reduced payment because of failure to file a proper claim, enter the amount that would have been payable had a proper claim been filed.
42	Veterans Affairs (VA) [Veterans Health Administration (VHA)]	That portion of a higher priority VA payment made on behalf of a Medicare beneficiary that the provider is applying to Medicare charges on this bill.
43	Disabled Beneficiary Under Age 65 With Large Group Health Plan (LGHP)	That portion of a higher priority LGHP payment made on behalf of a disabled beneficiary that the provider is applying to Medicare-covered charges on this bill. Enter 6 zeros (0000.00) into the amount field if claiming a conditional payment because the LGHP has denied coverage. If receiving no payment or a reduced payment because of failure to file a proper claim, enter the amount that would have been payable had a proper claim been filed.
44	Amount Provider Agreed to Accept From Primary Payer When this Amount is Less than Charges but Higher than Payment Received	The portion that the provider was obligated or required to accept from a primary payer as payment in full when that amount is less than charges but higher than the amount actually received. A Medicare secondary payment is due.
45	Accident Hour	The hour when the accident occurred that necessitated medical treatment. Enter the appropriate code right justified to the left of the dollar/cents delimiter.
46	Number of Grace Days	**Not used on Part B claims.**

Code	Title	Definition
47	Any Liability Insurance	That portion from a higher priority liability insurance paid on behalf of a Medicare beneficiary that the provider is applying to Medicare covered charges on this bill. Enter 6 zeros (0000.00) in the amount field if claiming a conditional payment because there has been a substantial delay in the other payer's payment.
48	Hemoglobin Reading	The latest hemoglobin reading taken before the start of this billing cycle. The provider reports in three positions (a percentage) to the left of the dollar/cent delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit.
49	Hematocrit Reading	The latest hematocrit reading taken before the start of this billing cycle. This is usually reported in two positions (a percentage) to the left of the dollar/cent delimiter. If the reading is provided with a decimal, the provider uses the position to the right of the delimiter for the third digit.
50	Physical Therapy Visits	The number of physical therapy visits from onset (at the billing provider) through this billing period. **NOTE:** Codes 50-57 represent the number of visits or hours of service provided. Entries for the number of visits should be right justified from the dollars/cents delimiter. For example, a total of 13 would be shown as: XXXXX13YY (Where Xs represent non-valued empty placeholders and Ys represent the non-valued dollars/cents delimiter placeholders.)

Code	Title	Definition
51	Occupational Therapy Visits	The number of occupational therapy visits from onset (at the billing provider) through this billing period. **NOTE:** Codes 50-57 represent the number of visits or hours of service provided. Entries for the number of visits should be right justified from the dollars/cents delimiter. For example, a total of 13 would be shown as: XXXXX13YY (Where Xs represent non-valued empty placeholders and Ys represent the non-valued zero or blank dollars/cents delimiter placeholders.)
52	Speech Therapy Visits	The number of speech therapy visits from onset (at the billing provider) through this billing period. **NOTE:** Codes 50-57 represent the number of visits or hours of service provided. Entries for the number of visits should be right justified from the dollars/cents delimiter. For example, a total of 13 would be shown as: XXXXX13YY (Where Xs represent non-valued empty placeholders and Ys represent the non-valued zero or blank dollars/cents delimiter placeholders.)

Code	Title	Definition
53	Cardiac Rehabilitation Visits	The number of cardiac rehabilitation visits from onset (at the billing provider) through this billing period. **NOTE:** Codes 50-57 represent the number of visits or hours of service provided. Entries for the number of visits should be right justified from the dollars/cents delimiter. For example, a total of 13 would be shown as: XXXXX13YY (Where Xs represent non-valued empty placeholders and Ys represent the non-valued zero or blank dollars/cents delimiter placeholders.)
54	Newborn Birth Weight in Grams	**Not used on Part B claims.**
55	Eligibility Threshold for Charity Care	Code identifies the corresponding value amount at which a health care facility determines the eligibility threshold for charity care. **NOTE:** Codes 50-57 represent the number of visits or hours of service provided. Entries for the number of visits should be right justified from the dollars/cents delimiter. For example, a total of 13 would be shown as: XXXXX13YY (Where Xs represent non-valued empty placeholders and Ys represent the non-valued dollars/cents delimiter placeholders.)

Code	Title	Definition
56	Skilled Nurse - Home Visit Hours [Home Health Agency (HHA) Only]	The number of hours of skilled nursing provided during the billing period. The provider counts only hours spent in the home. The total number of hours excludes travel time and is reported in whole hours, right justified to the left of the dollars/cents delimiter. The number of hours should be rounded to the nearest whole hour. **NOTE:** Codes 50-57 represent the number of visits or hours of service provided. Entries for the number of visits should be right justified from the dollars/cents delimiter. For example, a total of 13 would be shown as: XXXXX13YY (Where Xs represent non-valued empty placeholders and Ys represent the non-valued dollars/cents delimiter placeholders.)
57	Home Health Aide - Home Visit Hours [Home Health Agency (HHA) Only]	The number of hours of home health aide services provided during the billing period. The provider counts only hours spent in the home. The total number of hours excludes travel time and is reported in whole hours, right justified to the left of the dollars/cents delimiter. The number of hours should be rounded to the nearest whole hour. **NOTE:** Codes 50-57 represent the number of visits or hours of service provided. Entries for the number of visits should be right justified from the dollars/cents delimiter. For example, a total of 13 would be shown as: XXXXX13YY (Where Xs represent non-valued empty placeholders and Ys represent the non-valued dollars/cents delimiter placeholders.)

Code	Title	Definition
58	Arterial Blood Gas (PO2/PA2)	Indicates arterial blood gas value at the beginning of each reporting period for oxygen therapy. This value or value 59 is required on the initial bill for oxygen therapy and on the fourth month's bill. The provider reports right justified in the cents area. **NOTE:** This code is not a monetary amount. This code represents the patient's arterial blood gas level. This amount should be rounded to two decimals or the nearest whole percent. For example, a reading of 56.5 would be shown as: XXXXXXX57 (Where the Xs represent non-valued empty placeholders.)
59	Oxygen Saturation (02 Sat/Oximetry)	Indicates oxygen saturation at the beginning of each reporting period for oxygen therapy. This value or value 58 is required on the initial bill for oxygen therapy and on the fourth month's bill. The hospital reports right justified in the cents area. **NOTE:** This code is not a monetary amount. This code represents the patient's oxygen saturation level. This amount should be rounded to the nearest whole percent. For example, a reading of 100 percent saturation would be shown as: XXXXXX100 (Where the Xs represent non-valued empty placeholders.)

Code	Title	Definition
60	Home Health Agency (HHA) Branch Medical Savings Account (MSA)	The MSA (or rural state code) in which the HHA branch is located. The HHA reports the MSA when its branch location is different than the HHA's main location. The HHA reports the MSA number, right justified to the left of the dollar/cents delimiter.
61	Location Where Service is Furnished [Home Health Agency (HHA) and Hospice]	Medical Savings Account (MSA) number or Core Based Statistical Area (CBSA) number of the location where the home health or hospice service is delivered. The HHA reports the MSA number right justified to the left of the dollar/cents delimiter. For episodes in which the beneficiary's site of service changes from one MSA to another within the episode period, HHAs should submit the MSA code corresponding to the site of service at the end of the episode on the claim.
62	Home Health (HH) Visits - Part A (Internal Payer Use Only)	The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by Section 1812(a)(3) of the Social Security Act.
63	Home Health Visits - Part B (Internal Payer Use Only)	The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by Section 1812(a)(3) of the Social Security Act.

Code	Title	Definition
64	Home Health Reimbursement - Part A (Internal Payer Use Only)	The dollar amounts determined to be associated with the home health visits identified in a Value Code 62 amount. This Part A payment reflects the shift of payments from the Medicare Part A to the Medicare Part B Trust Fund as mandated by Section 1812(a)(3) of the Social Security Act.
65	Home Health Reimbursement - Part B (Internal Payer Use Only)	The dollar amounts determined to be associated with the home health visits identified in a Value Code 63 amount. This Part B payment reflects the shift of payments from the Medicare Part A to the Medicare Part B Trust Fund as mandated by Section 1812(a)(3) of the Social Security Act.
66	Medicare Spend-down Amount	The dollar amount that was used to meet the recipient's spend-down liability for this claim.
67	Peritoneal Dialysis	The number of hours of peritoneal dialysis provided during the billing period. The provider counts only the hours spent in the home, excluding travel time. The number of hours should be rounded to the nearest whole hour (reported in whole hours) and be right justified to the left of the dollar/cent delimiter.
68	Number of Units of Epoetin (EPO) Provided During the Billing Period	Indicates the number of units of EPO administered and/or supplied relating to the billing period. The provider reports in whole units to the left of the dollar/cent delimiter. For example, 31,060 units are administered for the billing period, thus, would be entered as follows: XX3 1 0 6 0.XX (Where the Xs represent non-valued empty placeholders.)

Code	Title	Definition
69	State Charity Care Percent	Indicates the percentage of charity care eligibility for the patient. Report the whole number right justified to the left of the dollar/cents delimiter, and fractional amounts to the right.
70	Interest Amount (Third-Party Payers Only)	The contractor reports the amount of interest applied to this Medicare claim.
71	Funding of End Stage Renal Disease (ESRD) Networks (Third-party Payer Only)	The Fiscal Intermediary (FI) reports the amount the Medicare payment was reduced to help fund ESRD networks.
72	Flat Rate Surgery Charge (Third-Party Payer Only)	The standard charge for outpatient surgery where the provider has such a charging structure.
73-74	Payer Codes (Third-Party Payer Only)	
75	Gramm/Rudman/Hollings (Third-Party Payer Internal Use Only)	The contractor reports the amount of sequestration.
76	Provider's Interim Rate (Third-Party Payer Internal Use Only)	Provider's percentage of billed charges interim rate during this billing period. This applies to all outpatient hospital and Skilled Nursing Facility (SNF) claims and Home Health Agency (HHA) claims to which an interim rate is applicable. The contractor reports to the left of the dollar/cents delimiter. For example, an interim rate of 50% would be entered as follows: XXXXX50.00 (Where the Xs represent non-valued empty placeholders.)
77	Medicare New Technology Add-On Payment	Indicates the amount of Medicare additional payment for new technology.
78-79	Payer Codes (Reserved for Third-Party Payer Internal Use Only)	CMS assigns as needed. Providers do not report payer codes.
80-99	Reserved for State Use	Reserved for state use. Discontinued effective October 16, 2003.

Code	Title	Definition
A0	Special Zip Code Reporting	The 5-digit Zip Code of the location from which the beneficiary is initially placed on board the ambulance.
A1	Deductible Payer A	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.
A2	Coinsurance Payer A	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. For Medicare, use this code only for reporting Part B coinsurance amounts. For Part A coinsurance amounts use Value Codes 8-11.
A3	Estimated Responsibility Payer A	Amount the provider estimates will be paid by the indicated payer.
A4	Covered Self-Administrable Drugs - Emergency	The amount included in covered charges for self-administrable drugs administered to the patient in an emergency situation. (The only covered Medicare charges for an ordinarily non-covered, self-administered drug are for insulin administered to a patient in a diabetic coma.) For use with Revenue Code 0637.
A5	Covered Self-Administrable Drugs - Not Self-Administrable in Form and Situation Furnished to Patient	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administrable in the form and situation in which it was furnished to the patient. For use with Revenue Code 0637.
A6	Covered Self-Administrable Drugs - Diagnostic Study and Other	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was necessary for diagnostic study or other reasons (e.g., the drug is specifically covered by the payer). For use with Revenue Code 0637.

Code	Title	Definition
A7	Copayment A	The amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer.
A8	Weight of Patient in Kilograms	Self-explanatory. Report this data only when the health plan has a predefined change in reimbursement that is affected by weight. For newborns use value code 5X (effective January 5, 2005). For dialysis treatments performed on double amputee dialysis patients on or after January 1, 2006, weight should be calculated based on pre-amputation weight using the following formula: Pre-amputation Weight = Actual Weight x 1.5
A9	Height of Patient in Centimeters	Self-explanatory. Report this data only when the health plan has a predefined change in reimbursement that is affected by height (effective January 5, 2005). For dialysis treatments performed on double amputee dialysis patients on or after January 1, 2006, height should be recorded as the pre-amputation height. Where feasible, this measurement may be obtained from Form 2728.
AA	Regulatory Surcharges, Assessments, Allowances, or Health Care-Related Taxes Payer A	The amount of regulatory surcharges, assessments, allowances or health care-related taxes pertaining to the indicated payer. Effective October 16, 2003.
AB	Other Assessments or Allowances Payer A	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective October 16, 2003.
AC-AZ	Reserved for National Assignment	Self-explanatory.
B1	Deductible Payer B	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.

Code	Title	Definition
B2	Coinsurance Payer B	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Value Codes 8-11.
B3	Estimated Responsibility Payer B	Amount the provider estimates will be paid by the indicated payer.
B4-B6	Reserved for National Assignment	Self-explanatory.
B7	Copayment Payer B	The amount the provider assumes will be applied toward the patient's copayment amount involving the indicated payer.
B8-B9	Reserved for National Assignment	Self-explanatory.
BA	Regulatory Surcharges, Assessments, Allowances, or Health Care-Related Taxes Payer B	The amount of regulatory surcharges, assessments, allowances, or health care-related taxes pertaining to the indicated payer. Effective October 16, 2003.
BB	Other Assessments or Allowances Payer B	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer.
BC-C0	Reserved for National Assignment	Self-explanatory.
C1	Deductible Payer C	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer. **NOTE:** Medicare blood deductibles should be reported under Value Code 6.
C2	Coinsurance Payer C	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Value Codes 8-11.
C3	Estimated Responsibility Payer C	Amount the provider estimates will be paid by the indicated payer.
C4-C6	Reserved for National Assignment	Self-explanatory.
C7	Copayment Payer C	The amount the provider assumes is applied to the patient's copayment amount involving the indicated payer.

Code	Title	Definition
C8-C9	Reserved for National Assignment	Self-explanatory.
CA	Regulatory Surcharges, Assessments, Allowances or Health Care-Related Taxes Payer C	The amount of regulatory surcharges, assessments, allowances or health care-related taxes pertaining to the indicated payer. Effective October 16, 2003.
CB	Other Assessments or Allowances Payer C	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective October 16, 2003.
CC-CZ	Reserved for National Assignment	Self-explanatory.
D0-D2	Reserved for National Assignment	Self-explanatory.
D3	Estimated Responsibility Patient	Amount the provider estimates will be paid by the indicated patient.
D4-DQ	Reserved for National Assignment	Self-explanatory.
DR	Reserved for Disaster Related Code	Self-explanatory.
DS-DZ	Reserved for National Assignment	Self-explanatory.
E0	Reserved for National Assignment	Self-explanatory.
E1	Deductible Payer D	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.
E2	Coinsurance Payer D	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer.
E3	Estimated Responsibility Payer D	Amount the provider estimates will be paid by the indicated payer.
E4-E6	Reserved for National Assignment	Self-explanatory.
E7	Copayment Payer D	The amount the provider assumes will be applied toward the patient's copayment amount involving the indicated payer.
E8-E9	Reserved for National Assignment	Self-explanatory.
EA	Regulatory Surcharges, Assessments, Allowances, or Health Care-Related Taxes Payer D	The amount of regulatory surcharges, assessments, allowances, or health care-related taxes pertaining to the indicated payer. Effective October 16, 2003.

Code	Title	Definition
EB	Other Assessments or Allowances Payer D	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective October 16, 2003.
EC-EZ	Reserved for National Assignment	Self-explanatory.
F0	Reserved for National Assignment	Self-explanatory.
F1	Deductible Payer E	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.
F2	Coinsurance Payer E	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer.
F3	Estimated Responsibility Payer E	Amount the provider estimates will be paid by the indicated payer.
F4-F6	Reserved for National Assignment	Self-explanatory.
F7	Copayment Payer E	The amount the provider assumes will be applied toward the patient's copayment amount involving the indicated payer.
F8-F9	Reserved for National Assignment	Self-explanatory.
FA	Regulatory Surcharges, Assessments, Allowances, or Health Care-Related Taxes Payer E	The amount of regulatory surcharges, assessments, allowances or health care-related taxes pertaining to the indicated payer. Effective October 16, 2003.
FB	Other Assessments or Allowances Payer E	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective October 16, 2003.
FC-FZ	Reserved for National Assignment	Self-explanatory.
G0	Reserved for National Assignment	Self-explanatory.
G1	Deductible Payer F	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.
G2	Coinsurance Payer F	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer.

Code	Title	Definition
G3	Estimated Responsibility Payer F	Amount the provider estimates will be paid by the indicated payer.
G4-G6	Reserved for National Assignment	Self-explanatory.
G7	Copayment Payer F	The amount the provider assumes will be applied toward the patient's copayment amount involving the indicated payer.
G8-G9	Reserved for National Assignment	Self-explanatory.
GA	Regulatory Surcharges, Assessments, Allowances, or Health Care-Related Taxes Payer F	The amount of regulatory surcharges, assessments, allowances, or health care-related taxes pertaining to the indicated payer. Effective October 16, 2003.
GB	Other Assessments or Allowances Payer F	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective October 16, 2003.
GC-GZ	Reserved for National Assignment	Self-explanatory.
H0-WZ	Reserved for National Assignment	Self-explanatory.
X0-Y0	Reserved for National Assignment	Self-explanatory.
Y1	Part A Demonstration Payment	This is the portion of the payment designated as reimbursement for Part A services under the demonstration. This amount is instead of the traditional prospective DRG payment (operating and capital) as well as any outlier payments that might have been applicable in the absence of the demonstration. No deductible or coinsurance has been applied. Payments for operating IME and DSH which are processed in the traditional manner are also not included in this amount.
Y2	Part B Demonstration Payment	This is the portion of the payment designated as reimbursement for Part B services under the demonstration. No deductible or coinsurance has been applied.

Code	Title	Definition
Y3	Part B Coinsurance	This is the amount of Part B coinsurance applied by the intermediary to this claim. For demonstration claims this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group).
Y4	Conventional Provider Payment Amount for Non-Demonstration Claims	This is the amount Medicare would have reimbursed the provider for Part A services if there had been no demonstration. This should include the prospective DRG payment (both capital as well as operational) as well as any outlier payment, which would be applicable. It does not include any pass through amounts such as that for direct medical education nor interim payments for operating IME and DSH.
Y5-ZZ	Reserved for National Assignment	Self-explanatory.

REFERENCE F: REVENUE CODES

The biller must provide detail level coding in Field Locator (FL)/Block 42 for the Revenue Code series listed below. Fourth digit zero level billing is encouraged for all other services; however, a Fiscal Intermediary (FI) may require detailed breakouts of other Revenue Code series from providers.

Important Note: Only Revenue Codes applicable to Medicare Part B billing are included within this reference section.

Code Series	Description
0290s	Rental/purchase of Durable Medical Equipment (DME)
0304	Renal dialysis/laboratory
0330s	Radiology therapeutic
0367	Kidney transplant
0420s-0440s	Therapies
0520s	Type or clinic visit [Rural Health Clinic (RHC) or other]
0550s-0590s	Home health services
0624	Investigational Device Exemption (IDE)
0636	Drugs requiring detailed coding, an extension of 25X
0800s-0850s	End Stage Renal Disease (ESRD) services
9000-9044	Medicare Skilled Nursing Facility (SNF) demonstration project

RURAL HEALTH CLINIC (RHC) AND FEDERALLY-QUALIFIED HEALTH CENTER (FQHC) REVENUE CODES

In general, RHCs and FQHCs use Revenue Codes 052X and 091X with appropriate subcategories to complete Form CMS-1450. The other codes provided are not generally used by RHCs and FQHCs and are provided for informational purposes only. Applicable codes and code series include:

- 0025-0033
- 0038-0044
- 0047
- 0055-0059
- 0061
- 0062
- 0064-0069
- 0073-0075
- 0077

- 0078
- 0092-0095

RENAL DIALYSIS CENTER REVENUE CODES

Renal dialysis centers bill the following Revenue Center Codes at the detailed level:

- 0304 - rental and dialysis/laboratory
- 0636 - hemophilia blood clotting factors
- 0800s-0850s - ESRD services

The remaining applicable codes include:

- 0025
- 0027
- 0031-0032
- 0038-0039
- 0075
- 0082-0088

HOSPICE REVENUE CODES

Hospice uses Revenue Code 0657 to identify its charges for services furnished to patients by physicians either employed by the hospice, or receiving compensation from the hospice. In conjunction with Revenue Code 0657, the hospice enters a physician procedure code in the right-hand margin of FL/Block 43 (to the right of the dotted line adjacent to the Revenue Code in FL/Block 42). Appropriate Procedure Codes are made available to the physician by the Fiscal Intermediary (FI). Procedure codes are required for the FI to make reasonable charge determinations when paying the hospice for physician services.

Hospice uses the Revenue Codes listed below to bill Medicare.

Code	Description	Standard Abbreviation	Notes
0651*	Routine Home Care	RTN Home	
0652*	Continuous Home Care	CTNS Home	A minimum of 8 hours, not necessarily consecutive, in a 24-hour period, is required. Less than 8 hours is routine home care for payment purposes. A portion of an hour is rounded up to 1 hour.

* The hospice must report Value Code 61 with this Revenue Code.

Code	Description	Standard Abbreviation	Notes
0655	Inpatient Respite Care	IP Respite	
0656	General Inpatient Care	GNL IP	
0657	Physician Services	PHY Ser	Must be accompanied by a physician procedure code.

REVENUE CENTER CODES FOR HOSPITAL AND SKILLED NURSING FACILITY (SNF) MEDICARE PART B INPATIENT SERVICES

The Revenue Center codes listed in the following table will **NOT** be reimbursed under Medicare Part B inpatient services for a hospital or SNF under Type of Bill (TOB) Code 11X or 22X.

010X	022X	0259	0370	052X	055X	0635	079X	0949
011X	023X	0261	0374	053X	057X	0637	093X	095X
012X	024X	0269	0379	0541	058X	064X	0940	096X
013X	0250	0270	041X	0542	059X	065X	0941	097X
014X	0251	0273	045X	0543	060X	066X	0943	098X
015X	0252	0277	0472	0544	0630	067X	0944	099X
016X	0253	0279	0479	0546	0631	068X	0945	100X
017X	0256	029X	049X	0547	0632	072X	0946	210X
018X	0257	0339	050X	0548	0633	0762	0947	310X
019X	0258	036X	051X	0549	0634	078X	0948	

REVENUE CENTER CODES FOR ALL PROVIDER TYPES

The Revenue Center Codes and associated subcategories in the following table are applicable for all provider types.

Revenue Code	Description	
0001	Total Charge - for use on paper or paper facsimile (e.g., “print images”) claims only. For electronic transactions, Fiscal Intermediaries (FIs) must report the total charge in the appropriate data segment/field.	
001X	Reserved for Internal Payer Use	
002X	Health Insurance Prospective Payment Systems (HIPPS)	
	Subcategory	**Standard Abbreviation**
	0 - Reserved	
	1 - Reserved	

Revenue Code	Description	
002X (Con't)	**Subcategory**	**Standard Abbreviations**
	2 - Skilled Nursing Facility Prospective Payment System	SNF PPS (RUG)
	3 - Home Health Prospective Payment System	HHS PPS (HRG)
	4 - Inpatient Rehabilitation Facility Prospective Payment System	IRF PPS (CMG)
	5 - Reserved	
	6 - Reserved	
	7 - Reserved	
	8 - Reserved	
	9 - Reserved	
003X-006X	Reserved for National Assignment	
007X-009X	Reserved for State Use (Valid until October 16, 2003. Thereafter, Reserved for National Assignment).	

ANCILLARY REVENUE CODES (022X-099X)

Revenue Code	Description	
022X	Special Charges	Charges incurred during an inpatient stay or on a daily basis for certain services. Rationale: Some hospitals prefer to identify the components of services furnished in greater detail and thus break out charges for items that normally would be considered part of routine services.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	SPECIAL CHARGES
	1 - Admission Charge	ADMIT CHARGE
	2 - Technical Support Charge	TECH SUPPT CHG
	3 - Utilization Review Service Charge	UR CHARGE
	4 - Late Discharge, Medically Necessary	LATE DISCH/MED NEC
	9 - Other Special Charges	OTHER SPEC CHG

Revenue Code	Description	
023X	Not applicable to Medicare Part B claims.	
024X	All Inclusive Ancillary	A flat rate charge incurred on either a daily basis or total stay basis for ancillary services only. Rationale: Hospitals that bill in this manner may wish to segregate these charges.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	ALL INCL ANCIL
	1 - Basic	ALL INCL BASIC
	2 - Comprehensive	ALL INCL COMP
	3 - Specialty	ALL INCL
	9 - Other All Inclusive Ancillary	ALL INCL ANCIL/OTHER
025X	Pharmacy	Indicates charges for medication produced, manufactured, packaged, controlled, assayed, dispensed, and distributed under the direction of a licensed pharmacist. Rationale: Additional breakdowns are provided for items that individual hospitals may wish to identify because of internal or third-party payer requirements. Subcode 4 is for hospitals that do not bill drugs used for other diagnostic services as part of the charge for the diagnostic service. Subcode 5 is for hospitals that do not bill drugs used for radiology under radiology Revenue Codes as part of the radiology procedure charge.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	PHARMACY
	1 - Generic Drugs	DRUGS/GENERIC
	2 - Non-generic Drugs	DRUGS/NONGENERIC
	3 - Take Home Drugs	DRUGS/TAKEHOME

Revenue Code	Description	
025X (Con't)	**Subcategory**	**Standard Abbreviations**
	4 - Drugs Incident to Other Diagnostic Services	DRUGS/INCIDENT ODX
	5 - Drugs Incident to Radiology	DRUGS/INCIDENT RAD
	6 - Experimental Drugs	DRUGS/EXPERIMT
	7 - Non-prescription	DRUGS/NONPSCRPT
	8 - IV Solutions	IV SOLUTIONS
	9 - Other	DRUGS/OTHER
026X	IV Therapy	Code indicates the administration of intravenous solution by specially trained personnel to individuals requiring such treatment. **NOTE:** For outpatient home intravenous drug therapy equipment, which is part of the basic per diem Fee Schedule, providers must identify the actual cost for each type of pump for updating of the per diem rate.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	IV THERAPY
	1 - Infusion Pump	IV THER/INFSN PUMP
	2 - IV Therapy/Pharmacy Services	IV THER/PHARM/SVC
	3 - IV Therapy/Drug/Supply/ Delivery	IV THER/DRUG/SUPPLY DELV
	4 - IV Therapy/Supplies	IV THER/SUPPLIES
	9 - Other IV Therapy	THERAPY/OTHER
027X	Medical/Surgical Supplies (Also see 062X, an extension of 027X)	Indicates charges for supply items required for patient care. Rationale: Additional breakdowns are provided for items that hospitals may wish to identify because of internal or third-party payer requirements.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	MED-SUR SUPPLIES
	1 - Non-sterile Supply	NONSTER SUPPLY

Revenue Code	Description	
027X (Con't)	**Subcategory**	**Standard Abbreviations**
	2 - Sterile Supply	STERILE SUPPLY
	3 - Take Home Supplies	TAKEHOME SUPPLY
	4 - Prosthetic/Orthotic Devices	PROSTH/ORTH DEV
	5 - Pace maker	PACE MAKER
	6 - Intraocular Lens	INTR OC LENS
	7 - Oxygen - Take Home	02/TAKEHOME
	8 - Other Implants	SUPPLY/IMPLANTS
	9 - Other Supplies/Devices	SUPPLY/OTHER
028X	Oncology	Indicates charges for the treatment of tumors and related diseases.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	ONCOLOGY
	9 - Other Oncology	ONCOLOGY/OTHER
029X	Durable Medical Equipment (DME) (Other Than Rental)	Indicates the charges for medical equipment that can withstand repeated use (excluding renal equipment). Rationale: Medicare requires a separate revenue center for billing.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	MED EQUIP/DURAB
	1 - Rental	MED EQUIP/RENT
	2 - Purchase of new DME	MED EQUIP/NEW
	3 - Purchase of used DME	MED EQUIP/USED
	4 - Supplies/Drugs for DME Effectiveness (HHAs Only)	MED EQUIP/SUPPLIES/DRUGS
	9 - Other Equipment	MED EQUIP/OTHER

Revenue Code	Description	
030X	Laboratory	Charges for the performance of diagnostic and routine clinical laboratory tests. Rationale: A breakdown of the major areas in the laboratory is provided to meet hospital needs or third-party billing requirements.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	LABORATORY or LAB
	1 - Chemistry	LAB/CHEMISTRY
	2 - Immunology	LAB/IMMUNOLOGY
	3 - Renal Patient (Home)	LAB/RENAL HOME
	4 - Non-routine Dialysis	LAB/NR DIALYSIS
	5 - Hematology	LAB/HEMATOLOGY
	6 - Bacteriology & Microbiology	LAB/BACT-MICRO
	7 - Urology	LAB/UROLOGY
	9 - Other Laboratory	LAB/OTHER
031X	Laboratory Pathological	Charges for diagnostic and routine laboratory tests on tissues and culture. Rationale: A breakdown of the major areas that hospitals may wish to identify is provided.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	PATHOLOGY LAB or PATH LAB
	1 - Cytology	PATHOL/CYTOLOGY
	2 - Histology	PATHOL/HYSTOL
	4 - Biopsy	PATHOL/BIOPSY
	9 - Other	PATHOL/OTHER

Revenue Code	Description	
032X	Radiology - Diagnostic	Charges for diagnostic radiology services provided for the examination and care of patients. Includes taking, processing, examining and interpreting radiographs and fluorographs. Rationale: A breakdown is provided for the major areas and procedures that individual hospitals or third-party payers may wish to identify.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	DX X-RAY
	1 - Angiocardiography	DX X-RAY/ANGIO
	2 - Arthrography	DX X-RAY/ARTH
	3 - Arteriography	DX X-RAY/ARTER
	4 - Chest X-ray	DX X-RAY/CHEST
	9 - Other	DX X-RAY/OTHER
033X	Radiology - Therapeutic	Charges for therapeutic radiology services and chemotherapy are required for care and treatment of patients. Includes therapy by injection or ingestion of radioactive substances. Rationale: A breakdown is provided for the major areas that hospitals or third-party payers may wish to identify. Chemotherapy - IV was added at the request of Ohio.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	RX X-RAY
	1 - Chemotherapy - Injected	CHEMOTHER/INJ
	2 - Chemotherapy - Oral	CHEMOTHER/ORAL
	3 - Radiation Therapy	RADIATION RX
	5 - Chemotherapy - IV	CHEMOTHERP-IV
	9 - Other	RX X-RAY/OTHER

Revenue Code	Description	
034X	Nuclear Medicine	Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients. Rationale: A breakdown is provided for the major areas that hospitals or third-party payers may wish to identify.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	NUCLEAR MEDICINE or NUC MED
	1 - Diagnostic Procedures	NUC MED/DX
	2 - Therapeutic Procedures	NUC MED/RX
	3 - Diagnostic Radiopharmaceuticals	NUC MED/DX RADIOPHARM Effective October 1, 2004.
	4 - Therapeutic Radiopharmaceuticals	NUC MED/RX RADIOPHARM Effective October 1, 2004.
	9 - Other	NUC MED/OTHER
035X	Computed Tomographic (CT) Scan	Charges for CT scans of the head and other parts of the body. Rationale: Due to coverage limitations, some third-party payers require that the specific test be identified.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	CT SCAN
	1 - Head Scan	CT SCAN/HEAD
	2 - Body Scan	CT SCAN/BODY
	9 - Other CT Scans	CT SCAN/OTHER

Revenue Code	Description	
036X	Operating Room Services	Charges for services provided to patients by specially trained nursing personnel who provide assistance to physicians in the performance of surgical and related procedures during and immediately following surgery as well the operating room (heat, lights) and equipment. Rationale: Permits identification of particular services.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	OR SERVICES
	1 - Minor Surgery	OR/MINOR
	2 - Organ Transplant - other than Kidney	OR/ORGAN TRANS
	7 - Kidney Transplant	OR/KIDNEY TRANS
	9 - Other Operating Room Services	OR/OTHER
037X	Anesthesia	Charges for anesthesia services in the hospital. Rationale: Provides additional identification of services. In particular, acupuncture was identified because some payers, including Medicare, do not cover it. Subcode 1 is for providers that do not bill anesthesia used for other diagnostic services as part of the charge for the diagnostic service. Subcode 2 is for providers that do not bill anesthesia used for radiology under radiology Revenue Codes as part of the radiology procedure charge.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	ANESTHESIA
	1 - Anesthesia Incident to RAD	ANESTHE/INCIDENT RAD
	2 - Anesthesia Incident to Other Diagnostic Services	ANESTHE/INCIDENT ODX
	4 - Acupuncture	ANESTHE/ACUPUNC
	9 - Other Anesthesia	ANESTHE/OTHER

Revenue Code	Description	
038X	Blood	Rationale: Charges for blood must be separately identified for private payer purposes.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	BLOOD
	1 - Packed Red Cells	BLOOD/PKD RED
	2 - Whole Blood	BLOOD/WHOLE
	3 - Plasma	BLOOD/PLASMA
	4 - Platelets	BLOOD/PLATELETS
	5 - Leucocytes	BLOOD/LEUCOCYTES
	6 - Other Components	BLOOD/COMPONENTS
	7 - Other Derivatives (Cryopricipitates)	BLOOD/DERIVATIVES
	9 - Other Blood	BLOOD/OTHER
039X	Blood Storage and Processing	Charges for the storage and processing of whole blood.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	BLOOD/STOR-PROC
	1 - Blood Administration (e.g., Transfusions)	BLOOD/ADMIN
	9 - Other Processing and Storage	BLOOD/OTHER STOR
040X	Other Imaging Services	
	Subcategory	**Standard Abbreviations**
	0 - General Classification	IMAGE SERVICE
	1 - Diagnostic Mammography	MAMMOGRAPHY
	2 - Ultrasound	ULTRASOUND
	3 - Screening Mammography	SCR MAMMOGRAPHY/GEN MAMMO
	4 - Positron Emission Tomography	PET SCAN
	9 - Other Imaging Services	OTHER IMAG SVS

Revenue Code	Description		
040X (Con't)	**NOTE:** Medicare will require hospitals to report the ICD-9 diagnosis codes (FL/Block 67) to substantiate imaging services for those beneficiaries considered high risk. The high-risk codes are as follows:		
	Codes	Definitions	High Risk Indicator
	V10.3	Personal History - Malignant neoplasm breast cancer	A personal history of breast cancer.
	V16.3	Family History - Malignant neoplasm breast cancer	A mother, sister, or daughter who has had breast cancer.
	V15.89	Other specified personal history representing hazards to health	Has not given birth before age 30 or a personal history of biopsy-proven benign breast disease.
041X	Respiratory Services	Charges for administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases. Rationale: Permits identification of particular services.	
	Subcategory	**Standard Abbreviations**	
	0 - General Classification	RESPIRATORY SVC	
	2 - Inhalation Services	INHALATION SVC	
	3 - Hyperbaric Oxygen Therapy	HYPERBARIC 02	
	9 - Other Respiratory Services	OTHER RESPIR SVS	
042X	Physical Therapy	Charges for therapeutic exercises, massage and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities. Rationale: Permits identification of particular services.	

Revenue Code	Description	
042X (Con't)	**Subcategory**	**Standard Abbreviations**
	0 - General Classification	PHYSICAL THERP
	1 - Visit Charge	PHYS THERP/VISIT
	2 - Hourly Charge	PHYS THERP/HOUR
	3 - Group Rate	PHYS THERP/GROUP
	4 - Evaluation or Re-evaluation	PHYS THERP/EVAL
	9 - Other Physical Therapy	OTHER PHYS THERP
043X	Occupational Therapy	Services provided by a qualified occupational therapy practitioner for therapeutic interventions to improve, sustain, or restore an individual's level of function in performance of activities of daily living and work, including: therapeutic activities, therapeutic exercises; sensorimotor processing; psychosocial skills training; cognitive retraining; fabrication and application of orthotic devices; and training in the use of orthotic and prosthetic devices; adaptation of environments; and application of physical agent modalities.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	OCCUPATION THER
	1 - Visit Charge	OCCUP THERP/VISIT
	2 - Hourly Charge	OCCUP THERP/HOUR
	3 - Group Rate	OCCUP THERP/GROUP
	4 - Evaluation or Re-evaluation	OCCUP THERP/EVAL
	9 - Other Occupational Therapy (may include restorative therapy)	OTHER OCCUP THER
044X	Speech-Language Pathology	Charges for services provided to persons with impaired functional communications skills or dysphagia.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	SPEECH PATHOL

Revenue Code	Description	
044X (Con't)	**Subcategory**	**Standard Abbreviations**
	1 - Visit Charge	SPEECH PATH/VISIT
	2 - Hourly Charge	SPEECH PATH/HOUR
	3 - Group Rate	SPEECH PATH/GROUP
	4 - Evaluation or Re-evaluation	SPEECH PATH/EVAL
	9 - Other Speech-Language Pathology	OTHER SPEECH PAT
045X	Emergency Room	Charges for emergency treatment to those ill and injured persons who require immediate unscheduled medical or surgical care. Rationale: Permits identification of particular items for payers. Under the provisions of the Emergency Medical Treatment and Active Labor Act (EMTALA), a hospital with an emergency department must provide, upon request and within the capabilities of the hospital, an appropriate medical screening examination and stabilizing treatment to any individual with an emergency medical condition and to any woman in active labor, regardless of the individual's eligibility for Medicare (Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985).
	Subcategory	**Standard Abbreviations**
	0 - General Classification	EMERG ROOM
	1 - EMTALA Emergency Medical Screening Services	ER/EMTALA
	2 - ER Beyond EMTALA Screening	ER/BEYOND EMTALA
	6 - Urgent Care	URGENT CARE
	9 - Other Emergency Room	OTHER EMER ROOM

<table>
<tr><th>Revenue Code</th><th colspan="2">Description</th></tr>
<tr><td rowspan="3">045X (Con't)</td><td colspan="2">NOTE: Observation or hold beds are not reported under this code. They are reported under Revenue Code 0762, "Observation Room". An "X" in the matrix below indicates an acceptable coding combination:
<table>
<tr><th></th><th>0450[a]</th><th>0451[b]</th><th>0452[c]</th><th>0456</th><th>0459</th></tr>
<tr><td>0450</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>0451</td><td></td><td>X</td><td>X</td><td>X</td><td></td></tr>
<tr><td>0452</td><td></td><td>X</td><td></td><td></td><td></td></tr>
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<tr><td>0459</td><td></td><td>X</td><td></td><td>X</td><td></td></tr>
</table></td></tr>
<tr><td colspan="2">a. General Classification Code 0450 should not be used in conjunction with any subcategory. The sum of Codes 0451 and 0452 is equivalent to Code 0450. Payers that do not require a breakdown should roll up Codes 0451 and 0452 into Code 0450.
b. Standalone usage of Code 0451 is acceptable when no services beyond an initial screening/assessment are rendered.
c. Standalone usage of Code 0452 is not acceptable.</td></tr>
<tr><td rowspan="4">046X</td><td>Pulmonary Function</td><td>Charges for tests that measure inhaled and exhaled gases and analysis of blood and for tests that evaluate the patient's ability to exchange oxygen and other gases.
Rationale: Permits identification of this service if it exists in the hospital.</td></tr>
<tr><td>Subcategory</td><td>Standard Abbreviations</td></tr>
<tr><td>0 - General Classification</td><td>PULMONARY FUNC</td></tr>
<tr><td>9 - Other Pulmonary Function</td><td>OTHER PULMON FUNC</td></tr>
<tr><td rowspan="5">047X</td><td>Audiology</td><td>Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.
Rationale: Permits identification of particular services.</td></tr>
<tr><td>Subcategory</td><td>Standard Abbreviations</td></tr>
<tr><td>0 - General Classification</td><td>AUDIOLOGY</td></tr>
<tr><td>1 - Diagnostic</td><td>AUDIOLOGY/DX</td></tr>
<tr><td>2 - Treatment</td><td>AUDIOLOGY/RX</td></tr>
<tr><td>9 - Other Audiology</td><td>OTHER AUDIOL</td></tr>
</table>

Revenue Code	Description	
048X	Cardiology	Charges for cardiac procedures furnished in a separate unit within the hospital. Such procedures include, but are not limited to, heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress test. Rationale: This category was established to reflect a growing trend to incorporate these charges in a separate unit.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	CARDIOLOGY
	1 - Cardiac Cath Lab	CARDIAC CATH LAB
	2 - Stress Test	STRESS TEST
	3 - Echo cardiology	ECHOCARDIOLOGY
	9 - Other Cardiology	OTHER CARDIOL
049X	Ambulatory Surgical Care	Charges for ambulatory surgery not covered by any other category.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	AMBUL SURG
	9 - Other Ambulatory Surgical Care	OTHER AMBL SURG **NOTE:** Observation or hold beds are not reported under this code. They are reported under Revenue Code 0762, “Observation Room”.
050X	Outpatient Services	Outpatient charges for services rendered to an outpatient who is admitted as an inpatient before midnight of the day following the date of service. This Revenue Code is no longer used for Medicare.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	OUTPATIENT SVS
	9 - Other Outpatient Services	OUTPATIENT/OTHER

Revenue Code	Description	
051X	Clinic	Clinic (non-emergency/scheduled outpatient visit) charges for providing diagnostic, preventive, curative, rehabilitative, and education services to ambulatory patients. Rationale: Provides a breakdown of some clinics that hospitals or third-party payers may require.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	CLINIC
	1 - Chronic Pain Center	CHRONIC PAIN CL
	2 - Dental Clinic	DENTAL CLINIC
	3 - Psychiatric Clinic	PSYCH CLINIC
	4 - OB-GYN Clinic	OB-GYN CLINIC
	5 - Pediatric Clinic	PEDS CLINIC
	6 - Urgent Care Clinic	URGENT CLINIC
	7 - Family Practice Clinic	FAMILY CLINIC
	9 - Other Clinic	OTHER CLINIC
052X	Free-standing Clinic	Rationale: Provides a breakdown of some clinics that hospitals or third-party payers may require.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	FREESTAND CLINIC
	1 - Rural Health-Clinic (Effective July 1,2006, will be changed to: Clinic visit by member to RHC/FQHC)	RURAL/CLINIC
	2 - Rural Health-Home (Effective July 1, 2006, will be changed to: Home visit by RHC/FQHC practitioner)	RURAL/HOME
	3 - Family Practice	FR/STD FAMILY CLINIC
	4 - Effective July 1, 2006 - Visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF	

Revenue Code	Description	
052X (Con't)	5 - Effective July 1, 2006 - Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility	
	6 - Urgent Care Clinic	FR/STD URGENT CLINIC
	7 - Effective July 1, 2006 - RHC/FQHC Visiting Nurse Service(s) to a member's home when in a home health shortage area	
	8 - Effective July 1, 2006 - Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g. scene of accident)	
	9 - Other Freestanding Clinic	OTHER FR/STD CLINIC
053X	Osteopathic Services	Charges for a structural evaluation of the cranium, entire cervical, dorsal, and lumbar spine by a doctor of osteopathy. Rationale: This is a service unique to osteopathic hospitals and cannot be accommodated in any of the existing codes.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	OSTEOPATH SVS
	1 - Osteopathic Therapy	OSTEOPATH RX
	9 - Other Osteopathic Services	OTHER OSTEOPATH
054X	Ambulance	Charges for ambulance service usually on an unscheduled basis to the ill and injured who require immediate medical attention. Rationale: Provides subcategories that third-party payers or hospitals may wish to recognize. Heart mobile is a specially designed ambulance transport for cardiac patients.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	AMBULANCE

Revenue Code	Description	
054X (Con't)	**Subcategory**	**Standard Abbreviations**
	1 - Supplies	AMBUL/SUPPLY
	2 - Medical Transport	AMBUL/MED TRANS
	3 - Heart Mobile	AMBUL/HEARTMOBL
	4 - Oxygen	AMBUL/OXY
	5 - Air Ambulance	AIR AMBULANCE
	6 - Neo-natal Ambulance	AMBUL/NEO-NATAL
	7 - Pharmacy	AMBUL/PHARMACY
	8 - Telephone Transmission (EKG)	AMBUL/TELEPHONIC EKG
	9 - Other Ambulance	OTHER AMBULANCE
055X	Skilled Nursing	Charges for nursing services that must be provided under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result. This code may be used for nursing home services or a service charge for home health billing.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	SKILLED NURSING
	1 - Visit Charge	SKILLED NURS/VISIT
	2 - Hourly Charge	SKILLED NURS/HOUR
	9 - Other Skilled Nursing	SKILLED NURS/OTHER
056X	Medical Social Services	Charges for services such as counseling patients, interviewing patients, and interpreting problems of social situations rendered to patients on any basis. Rationale: Necessary for Medicare home health billing requirements. May be used at other times as required by hospital.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	MED SOCIAL SVS
	1 - Visit Charge	MED SOC SERV/VISIT
	2 - Hourly Charge	MED SOC SERV/HOUR
	9 - Other Med. Soc. Services	MED SOC SERV/OTHER

Revenue Code	Description	
057X	Home Health Aide (Home Health)	Charges made by a Home Health Agency (HHA) for personnel that are primarily responsible for the personal care of the patient. Rationale: Necessary for Medicare home health billing requirements.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	AIDE/HOME HEALTH
	1 - Visit Charge	AIDE/HOME HLTH/VISIT
	2 - Hourly Charge	AIDE/HOME HLTH/HOUR
	9 - Other Home Health Aide	AIDE/HOME HLTH/OTHER
058X	Other Visits (Home Health)	Code indicates charges by a Home Health Agency (HHA) for visits other than physical therapy, occupational therapy or speech therapy, which must be specifically identified. Rationale: This breakdown is necessary for Medicare home health billing requirements.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	VISIT/HOME HEALTH
	1 - Visit Charge	VISIT/HOME HLTH/VISIT
	2 - Hourly Charge	VISIT/HOME HLTH/HOUR
	3 - Assessment	VISIT/HOME HLTH/ASSES
	9 - Other Home Health Visits	VISIT/HOME HLTH/OTHER
059X	Units of Service (Home Health)	This Revenue Code is used by a Home Health Agency (HHA) that bills on the basis of units of service. Rationale: This breakdown is necessary for Medicare home health billing requirements.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	UNIT/HOME HEALTH
	9 - Home Health Other Units	UNIT/HOME HLTH/OTHER

Revenue Code	Description	
060X	Oxygen (Home Health)	Code indicates charges by a Home Health Agency (HHA) for oxygen equipment, supplies or contents, excluding purchased equipment. If a beneficiary had purchased a stationary oxygen system, oxygen concentrator or portable equipment, current Revenue Codes 0292 or 0293 apply. Durable Medical Equipment (DME) (other than oxygen systems) is billed under current Revenue Codes 0291, 0292, or 0293. Rationale: Medicare requires detailed revenue coding. Therefore, codes for this series may not be summed at the zero level.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	02/HOME HEALTH
	1 - Oxygen - State/Equip/Suppl or Cont	02/EQUIP/SUPPL/CONT
	2 - Oxygen - Stat/Equip/Suppl Under 1 LPM	02/STAT EQUIP/UNDER 1 LPM
	3 - Oxygen - Stat/Equip/Over 4 LPM	02/STAT EQUIP/OVER 4 LPM
	4 - Oxygen - Portable Add-on	02/STAT EQUIP/PORT ADD-ON
061X	Magnetic Resonance Imaging (MRI)	Indicates charges for MRI and Magnetic Resonance Angiography (MRA) of the brain and other parts of the body. Rationale: Due to coverage limitations, some third-party payers require that the specific test be identified.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	MRI
	1 - Brain (including Brainstem)	MRI - BRAIN
	2 - Spinal Cord (including spine)	MRI - SPINE
	3 - Reserved	

Revenue Code	Description	
061X (Con't)	**Subcategory**	**Standard Abbreviations**
	4 - MRI - Other	MRI - OTHER
	5 - MRA - Head and Neck	MRA - HEAD AND NECK
	6 - MRA - Lower Extremities	MRA - LOWER EXT
	7 - Reserved	
	8 - MRA - Other	MRA - OTHER
	9 - MRI - Other	MRI - OTHER
062X	Medical/Surgical Supplies - Extension of 027X	Code indicates charges for supply items required for patient care. The category is an extension of 027X for reporting additional breakdown where needed. Subcode 1 is for hospitals that do not bill supplies used for radiology Revenue Codes as part of the radiology procedure charges. Subcode 2 is for providers that cannot bill supplies used for other diagnostic procedures.
	Subcategory	**Standard Abbreviations**
	1 - Supplies Incident to Radiology	MED-SUR SUPP/INCIDNT RAD
	2 - Supplies Incident to Other Diagnostic Services	MED-SUR SUPP/INCIDNT ODX
	3 - Surgical Dressings	SURG DRESSING
	4 - Investigational Device	IDE
063X	Pharmacy - Extension of 025X	Code indicates charges for drugs and biologicals requiring specific identification as required by the payer. If HCPCS Codes are used to describe the drug, enter the HCPCS Code in FL/Block 44.
	Subcategory	**Standard Abbreviations**
	0 - RESERVED (Effective January 1, 1998)	
	1 - Single Source Drug	DRUG/SNGLE
	2 - Multiple Source Drug	DRUG/MULT
	3 - Restrictive Prescription	DRUG/RSTR

Revenue Code	Description	
063X (Con't)	4 - Erythropoietin (EPO) less than 10,000 units	DRUG/EPO < 10,000 units
	5 - Erythropoietin (EPO) 10,000 or More Units	DRUG/EPO >10,000 units
	6 - Drugs Requiring Detailed Coding (a)	DRUGS/DETAIL CODE
	7 - Self-administrable Drugs (b)	DRUGS/SELFADMIN
	NOTES: (a) Charges for drugs and biologicals (with the exception of radiopharmaceuticals, which are reported under Revenue Codes 0343 and 0344) requiring specific identifications as required by the payer (effective October 1, 2004). If HCPCS Codes are used to describe the drug, enter the HCPCS Code in FL/Block 44. The specified units of service to be reported are to be in hundreds (100s) rounded to the nearest hundred (no decimal). (b) Refer to Value Codes A4 and A5.	
064X	Home IV Therapy Services	Charge for IV drug therapy services that are performed in the patient's residence. For Home IV providers, the HCPCS Code must be entered for all equipment and all types of covered therapy.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	IV THERAPY SVC
	1 - Non-routine Nursing, Central Line	NON RT NURSING/CENTRAL
	2 - IV Site Care, Central Line	IV SITE CARE/CENTRAL
	3 - IV Start/Change Peripheral Line	IV STRT/CHNG/PERIPHRL
	5 - Training Patient/Caregiver, Central Line	TRNG/PT/CARGVE/CENTRAL
	6 - Training, Disabled Patient, Central Line	TRNG DSBLPT/CENTRAL
	7 - Training Patient/Caregiver, Peripheral Line	TRNG/PT/CARGVR/PERIPHRL

Revenue Code	Description	
064X (Con't)	**Subcategory**	**Standard Abbreviations**
	8 - Training, Disabled Patient, Peripheral Line	TRNG/DSBLPAT/PERIPHRL
	9 - Other IV Therapy Services	OTHER IV THERAPY SVC
	NOTE: Units need to be reported in 1-hour increments. Revenue Code 0642 relates to the HCPCS Code.	
065X	Hospice Services	Code indicates charges for hospice care services for a terminally ill patient if the patient elects these services in lieu of other services for the terminal condition. Rationale: The level of hospice care that is provided each day during a hospice election period determines the amount of Medicare payment for that day.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	HOSPICE
	1 - Routine Home Care	HOSPICE/RTN HOME
	2 - Continuous Home Care	HOSPICE/CTNS HOME
	3 - RESERVED	
	4 - RESERVED	
	5 - Inpatient Respite Care	HOSPICE/IP RESPITE
	6 - General Inpatient Care (non-respite)	HOSPICE/IP NON RESPITE
	7 - Physician Services	HOSPICE/PHYSICIAN
066X	Respite Care (HHA Only)	Charge for hours of care under the respite care benefit for services of a homemaker or home health aide, personal care services, and nursing care provided by a licensed professional nurse.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	RESPITE CARE
	1 - Hourly Charge/ Nursing	RESPITE/ NURSE
	2 - Hourly Charge/Aide/ Homemaker/Companion	RESPITE/AID/HMEMKE/COMP
	3 - Daily Respite Charge	RESPITE DAILY
	9 - Other Respite Care	RESPITE/CARE

Revenue Code	Description	
067X	Outpatient Special Residence Charges	Residence arrangements for patients requiring continuous outpatient care.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	OP SPEC RES
	1 - Hospital Based	OP SPEC RES/HOSP BASED
	2 - Contracted	OP SPEC RES/CONTRACTED
	9 - Other Special Residence Charges	OP SPEC RES/OTHER
068X	Trauma Response	Charges for a trauma team activation.
	Subcategory	**Standard Abbreviations**
	0 - Not Used	
	1 - Level I	TRAUMA LEVEL I
	2 - Level II	TRAUMA LEVEL II
	3 - Level III	TRAUMA LEVEL III
	4 - Level IV	TRAUMA LEVEL IV
	9 - Other Trauma Response	TRAUMA OTHER
	Usage Notes: 1. To be used by trauma center/hospitals as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation. 2. Revenue Code 068X is used for patients for whom a trauma activation occurred. A trauma team activation/response is a “Notification of key hospital personnel in response to triage information from pre-hospital caregivers in advance of the patient’s arrival”. 3. Revenue Code 068X is for reporting trauma activation costs only. It is an activation fee and not a replacement or a substitute for the emergency room visit fee; if trauma activation occurs, there will normally be both a 045X and 068X Revenue Code reported. 4. Revenue Code 068X is not limited to admitted patients. 5. Revenue Code 068X must be used in conjunction with FL/Block 19 Type of Admission/Visit code 05 (“Trauma Center”), however FL/Block 19 Code 05 can be used alone. Only patients for who there has been **pre-hospital** notification, who meet either local, state or American College of Surgeons field triage criteria, or are delivered by inter-hospital transfers, and are given the appropriate team response, can be billed the trauma activation fee charge. Patients who are “drive-by” or arrive without notification cannot be charged for activations, but can be classified as trauma under Type of Admission Code 5 for statistical and follow-up purposes.	

Revenue Code	Description	
068X (Con't)	6. Levels I, II, III or IV refer to designations by the state or local government authority, or as verified by the American College of Surgeons. 7. Subcategory 9 is for state or local authorities with levels beyond IV.	
069X	Not Assigned	
070X	Cast Room	Charges for services related to the application, maintenance and removal of casts. Rationale: Permits identification of this service, if necessary.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	CAST ROOM
	9 - Other Cast Room	OTHER CAST ROOM
071X	Recovery Room	Rationale: Permits identification of particular services, if necessary.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	RECOVERY ROOM
	9 - Other Recovery Room	OTHER RECOV ROOM
072X	Labor Room/Delivery	Charges for labor and delivery room services provided by specially trained nursing personnel to patients, including prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if they are performed in the delivery suite. Rationale: Provides a breakdown of items that may require further clarification. Infant circumcision is included because not all third-party payers cover it.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	DELIVROOM/LABOR
	1 - Labor	LABOR
	2 - Delivery	DELIVERY ROOM
	3 - Circumcision	CIRCUMCISION
	4 - Birthing Center	BIRTHING CENTER
	9 - Other Labor Room/Delivery	OTHER/DELIV-LABOR

Revenue Code	Description	
073X	Electrocardiogram (EKG/ECG)	Charges for operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiograph for diagnosis of heart ailments.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	EKG/ECG
	1 - Holter Monitor	HOLTER MONT
	2 - Telemetry	TELEMETRY
	9 - Other EKG/ECG	OTHER EKG-ECG
074X	Electroencephalogram (EEG)	Charges for operation of specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	EEG
	9 - Other EEG	OTHER EEG
075X	Gastro-Intestinal Services	Procedure room charges for endoscopic procedures not performed in an operating room.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	GASTR-INTS SVS
	9 - Other Gastro-Intestinal	OTHER GASTRO-INTS

Revenue Code	Description	
076X	Treatment or Observation Room	Charges for the use of a treatment room or for the room charge associated with outpatient observation services. Only 0762 should be used for observation services. Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. Most observation services do not exceed one day. Some patients, however, may require a second day of outpatient observation services. The reason for observation must be stated in the orders for observation. The payer should establish written guidelines that identify coverage of observation services.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	TREATMENT/OBSERVATION RM
	1 - Treatment Room	TREATMENT RM
	2 - Observation Room	OBSERVATION RM
	9 - Other Treatment Room	OTHER TREATMENT RM
077X	Preventive Care Services	Charges for the administration of vaccines.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	PREVENT CARE SVS
	1 - Vaccine Administration	VACCINE ADMIN
	9 - Other	OTHER PREVENT
078X	Telemedicine	Future use to be announced - Medicare Demonstration Project.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	TELEMEDICINE
	9 - Other Telemedicine	TELEMEDICINE/OTHER

Revenue Code	Description	
079X	Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy)	Charges related to Extra-Corporeal Shock Wave Therapy (ESWT).
	Subcategory	**Standard Abbreviations**
	0 - General Classification	ESWT
	9 - Other ESWT	ESWT/OTHER
080X	Inpatient Renal Disease	A waste removal process performed in an inpatient setting, that uses an artificial kidney when the body's own kidneys have failed. The waste may be removed directly from the blood (hemodialysis) or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue (peritoneal dialysis). Rationale: Specific identification required for billing purposes.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	RENAL DIALYSIS
	1 - Inpatient Hemodialysis	DIALY/INPT
	2 - Inpatient Peritoneal (Non-CAPD)	DIALY/INPT/PER
	3 - Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)	DIALY/INPT/CAPD
	4 - Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)	DIALY/INPT/CCPD
	9 - Other Inpatient Dialysis	DIALY/INPT/OTHER
081X	Organ Acquisition	The acquisition and storage costs of body tissue, bone marrow, organs and other body components not otherwise identified used for transplantation. Rationale: Living donor is a living person from whom various organs are obtained for transplantation. Cadaver is an individual who has been pronounced dead according to medical and legal criteria, from whom various organs are obtained for transplantation. Medicare requires detailed revenue coding. Therefore, codes for this series may not be summed at the zero level.

Revenue Code	Description	
081X (Con't)	**Subcategory**	**Standard Abbreviations**
	0 - General Classification	ORGAN ACQUISIT
	1 - Living Donor	LIVING/DONOR
	2 - Cadaver Donor	CADAVER/DONOR
	3 - Unknown Donor	UNKNOWN/DONOR
	4 - Unsuccessful Organ Search Donor Bank Charge*	UNSUCCESSFUL SEARCH
	9 - Other Organ Acquisition	OTHER/DONOR
	* Revenue code 0814 is used only when costs incurred for an organ search do not result in an eventual organ acquisition and transplantation.	
082X	Hemodialysis - Outpatient or Home Dialysis	A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood. Rationale: Detailed revenue coding is required. Therefore, services may not be summed at the zero level.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	HEMO/OP OR HOME
	1 - Hemodialysis/Composite or Other Rate	HEMO/COMPOSITE
	2 - Home Supplies	HEMO/HOME/SUPPL
	3 - Home Equipment	HEMO/HOME/EQUIP
	4 - Maintenance/100%	HEMO/HOME/100%
	5 - Support Services	HEMO/HOME/SUPSERV
	9 - Other Hemodialysis Outpatient	HEMO/HOME/OTHER

Revenue Code	Description	
083X	Peritoneal Dialysis - Outpatient or Home	A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	PERITONEAL/OP OR HOME
	1 - Peritoneal/Composite or Other Rate	PERTNL/COMPOSITE
	2 - Home Supplies	PERTNL/HOME/SUPPL
	3 - Home Equipment	PERTNL/HOME/EQUIP
	4 - Maintenance/100%	PERTNL/HOME/100%
	5 - Support Services	PERTNL/HOME/SUPSERV
	9 - Other Peritoneal Dialysis	PERTNL/HOME/OTHER
084X	Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home	A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	CAPD/OP OR HOME
	1 - CAPD/Composite or Other Rate	CAPD/COMPOSITE
	2 - Home Supplies	CAPD/HOME/SUPPL
	3 - Home Equipment	CAPD/HOME/EQUIP
	4 - Maintenance/100%	CAPD/HOME/100%
	5 - Support Services	CAPD/HOME/SUPSERV
	9 - Other CAPD Dialysis	CAPD/HOME/OTHER
085X	Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient	A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	CCPD/OP OR HOME
	1 - CCPD/Composite or Other Rate	CCPD/COMPOSITE
	2 - Home Supplies	CCPD/HOME/SUPPL

Revenue Code	Description	
085X (Con't)	**Subcategory**	**Standard Abbreviations**
	3 - Home Equipment	CCPD/HOME/EQUIP
	4 - Maintenance/100%	CCPD/HOME/100%
	5 - Support Services	CCPD/HOME/SUPSERV
	9 - Other CCPD Dialysis	CCPD/HOME/OTHER
086X	Reserved for Dialysis (National Assignment)	
087X	Reserved for Dialysis (National Assignment)	
088X	Miscellaneous Dialysis	Charges for dialysis services not identified elsewhere. Rationale: Ultra-filtration is the process of removing excess fluid from the blood of dialysis patients by using a dialysis machine but without the dialysate solution. The designation is used only when the procedure is not performed as part of a normal dialysis session.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	DIALY/MISC
	1 - Ultra-filtration	DIALY/ULTRAFILT
	2 - Home Dialysis Aid Visit	HOME DIALYSIS AID VISIT
	9 - Other Miscellaneous Dialysis	DIALY/MISC/OTHER
089X	Reserved for National Assignment	
090X	Behavior Health Treatments/Services (also see 091X, an extension of 090X)	Code indicates charges for providing nursing care and professional services for emotionally disturbed patients. This includes patients admitted for diagnosis and those admitted for treatment.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	BH
	1 - Electroshock Treatment	BH/ELECTRO SHOCK
	2 - Milieu Therapy	BH/MILIEU THERAPY
	3 - Play Therapy	BH/PLAY THERAPY

Revenue Code	Description	
090X (Con't)	**Subcategory**	**Standard Abbreviations**
	4 - Activity Therapy	BH/ACTIVITY THERAPY
	5 - Intensive Outpatient Services-Psychiatric	BH/INTENS OP/PSYCH
	6 - Intensive Outpatient Services-Chemical Dependency	BH/INTENS OP/CHEM DEP
	7 - Community Behavioral Health Program (Day Treatment)	BH/COMMUNITY
	8 - Reserved for National Use	
	9 - Reserved for National Use	
091X	Behavioral Health Treatment/Services-Extension of 090X	Code indicates charges for providing nursing care and professional services for emotionally disturbed patients. This includes patients admitted for diagnosis and those admitted for treatment. Subcategories 0912 and 0913 are designed as zero-billed Revenue Codes (no dollars in the amount field) to be used as a vehicle to supply program information, as defined in the provider/payer contract.
	Subcategory	**Standard Abbreviations**
	0 - Reserved for National Assignment	
	1 - Rehabilitation	BH/REHAB
	2 - Partial Hospitalization* - Less Intensive	BH/PARTIAL HOSP
	3 - Partial Hospitalization* - Intensive	BH/PARTIAL INTENSIVE
	4 - Individual Therapy	BH/INDIV RX
	5 - Group Therapy	BH/GROUP RX
	6 - Family Therapy	BH/FAMILY RX
	7 - Bio Feedback	BH/BIOFEED
	8 - Testing	BH/TESTING
	9 - Other Behavior Health Treatments/Services	BH/OTHER

Revenue Code	Description	
091X (Con't)	**Subcategory**	**Standard Abbreviations**
	* Medicare does not recognize codes 0912 and 0913 services under its partial hospitalization program.	
092X	Other Diagnostic Services	Code indicates charges for other diagnostic services not otherwise categorized.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	OTHER DX SVS
	1 - Peripheral Vascular Lab	PERI VASCUL LAB
	2 - Electromyelogram	EMG
	3 - Pap Smear	PAP SMEAR
	4 - Allergy Test	ALLERGY TEST
	5 - Pregnancy Test	PREG TEST
	9 - Other Diagnostic Service	ADDITIONAL DX SVS
093X	Medical Rehabilitation Day Program	Medical rehabilitation services as contracted with a payer and/or certified by the state. Services may include physical therapy, occupational therapy, and speech therapy. The subcategories of 093X are designed as zero-billed Revenue Codes (i.e., no dollars in the amount field) to be used as a vehicle to supply program information as defined in the provider/payer contract. Therefore, zero would be reported in FL/Block 47 and the number of hours provided would be reported in FL/Block 46. The specific rehabilitation services would be reported under the applicable Revenue Codes as normal.
	Subcategory	**Standard Abbreviations**
	1 - Half Day	HALF DAY
	2 - Full Day	FULL DAY
094X	Other Therapeutic Services (also see 095X, an extension of 094X)	Code indicates charges for other therapeutic services not otherwise categorized.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	OTHER RX SVS
	1 - Recreational Therapy	RECREATION RX

Revenue Code	Description	
094X (Con't)	**Subcategory**	**Standard Abbreviations**
	2 - Education/Training (includes Diabetes-related dietary therapy)	EDUC/TRAINING
	3 - Cardiac Rehabilitation	CARDIAC REHAB
	4 - Drug Rehabilitation	DRUG REHAB
	5 - Alcohol Rehabilitation	ALCOHOL REHAB
	6 - Complex Medical Equipment Routine	COMPLX MED EQUIP-ROUT
	7 - Complex Medical Equipment Ancillary	COMPLX MED EQUIP-ANC
	9 - Other Therapeutic Services	ADDITIONAL RX SVS
095X	Other Therapeutic Services-Extension of 094X	Charges for other therapeutic services not otherwise categorized.
	Subcategory	**Standard Abbreviations**
	0 - Reserved	
	1 - Athletic Training	ATHLETIC TRAINING
	2 - Kinesiotherapy	KINESIOTHERAPY
096X	Professional Fees	Charges for medical professionals that hospitals or third-party payers require to be separately identified on the billing form. Services that were not identified separately prior to uniform billing implementation should not be separately identified on the uniform bill.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	PRO FEE
	1 - Psychiatric	PRO FEE/PSYCH
	2 - Ophthalmology	PRO FEE/EYE
	3 - Anesthesiologist (MD)	PRO FEE/ANES MD
	4 - Anesthetist (CRNA)	PRO FEE/ANES CRNA
	9 - Other Professional Fees	OTHER PRO FEE

Revenue Code	Description	
097X	Professional Fees - Extension of 096X	
	Subcategory	**Standard Abbreviations**
	1 - Laboratory	PRO FEE/LAB
	2 - Radiology - Diagnostic	PRO FEE/RAD/DX
	3 - Radiology - Therapeutic	PRO FEE/RAD/RX
	4 - Radiology - Nuclear Medicine	PRO FEE/NUC MED
	5 - Operating Room	PRO FEE/OR
	6 - Respiratory Therapy	PRO FEE/RESPIR
	7 - Physical Therapy	PRO FEE/PHYSI
	8 - Occupational Therapy	PRO FEE/OCUPA
	9 - Speech Pathology	PRO FEE/SPEECH
098X	Professional Fees - Extension of 096X & 097X	
	Subcategory	**Standard Abbreviations**
	1 - Emergency Room	PRO FEE/ER
	2 - Outpatient Services	PRO FEE/OUTPT
	3 - Clinic	PRO FEE/CLINIC
	4 - Medical Social Services	PRO FEE/SOC SVC
	5 - EKG	PRO FEE/EKG
	6 - EEG	PRO FEE/EEG
	7 - Hospital Visit	PRO FEE/HOS VIS
	8 - Consultation	PRO FEE/CONSULT
	9 - Private Duty Nurse	FEE/PVT NURSE
099X	Patient Convenience Items	Not used on Medicare Part B claims.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	PT CONVENIENCE
	1 - Cafeteria/Guest Tray	CAFETERIA
	2 - Private Linen Service	LINEN
	3 - Telephone/Telegraph	TELEPHONE

Revenue Code	Description	
099X (Con't)	**Subcategory**	**Standard Abbreviations**
	4 - TV/Radio	TV/RADIO
	5 - Non-patient Room Rentals	NONPT ROOM RENT
	6 - Late Discharge Charge	LATE DISCHARGE
	7 - Admission Kits	ADMIN KITS
	8 - Beauty Shop/Barber	BARBER/BEAUTY
	9 - Other Patient Convenience Items	PT CONVENCE/OTH
100X	Behavioral Health Accommodations	Not used on Part B claims.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	BH R&B
	1 - Residential Treatment - Psychiatric	BH - R&B RES/PSYCH
	2 - Residential Treatment - Chemical Dependency	BH R&B RES/CHEM DEP
	3 - Supervised Living	BH R&B SUP LIVING
	4 - Halfway House	BH R&B HALFWAY HOUSE
	5 - Group Home	BH R&B GROUP HOME
101X-209X	Reserved for National Assignment	
210X	Alternative Therapy Services	Charges for therapies not elsewhere categorized under other therapeutic service Revenue Codes (042X, 043X, 044X, 091X, 094X, 095X) or services such as anesthesia or clinic (0374, 0511). Alternative therapy is intended to enhance and improve standard medical treatment. The following Revenue Code(s) would be used to report services in a separately designated alternative inpatient/outpatient unit.
	Subcategory	**Standard Abbreviations**
	0 - General Classification	ALTTHERAPY
	1 - Acupuncture	ACUPUNCTURE
	2 - Accupressure	ACCUPRESSURE

Revenue Code	Description	
210X (Con't)	**Subcategory**	**Standard Abbreviations**
	3 - Massage	MASSAGE
	4 - Reflexology	REFLEXOLOGY
	5 - Biofeedback	BIOFEEDBACK
	6 - Hypnosis	HYPNOSIS
	9 - Other Alternative Therapy Service	OTHER THERAPY
211X-300X	Reserved for National Assignment	
310X	Adult Care Effective April 1, 2003.	Charges for personal, medical, psycho-social, and/or therapeutic services in a special community setting for adults needing supervision and/or assistance with Activities of Daily Living (ADLs).
	Subcategory	**Standard Abbreviations**
	0 - Not Used	
	1 - Adult Day Care, Medical and Social - Hourly	ADULT MED/SOC HR
	2 - Adult Day Care, Social - Hourly	ADULT SOC HR
	3 - Adult Day Care, Medical and Social - Day	ADULT MED/SOC DAY
	4 - Adult Day Care, Social - Daily	ADULT SOC DAY
	5 - Adult Foster Care - Daily	ADULT FOSTER CARE
	9 - Other Adult Care	OTHER ADULT
311X-899X	Reserved for National Assignment	
9000-9044	Reserved for Medicare Skilled Nursing Facility Demonstration Project	
9045-9099	Reserved for National Assignment	

REFERENCE G: RELATIONSHIP CODES

The Program Transmittal 1881 (Change Request 2655) provided instruction on the various patient relationships to the insured codes that should be used as of October 16, 2003, in Field Locator (FL)/Block 59 A, B, and C. In this Program Transmittal, the Centers for Medicare & Medicaid Services (CMS) reported that the Common Working File (CWF) Medicare Secondary Payer (MSP) auxiliary file currently cannot associate the newly-established Individual Relationship Codes which can be found in the *Health Insurance Portability and Accountability Act (HIPAA) 837 Institutional and/or Professional Implementation Guides (version 4010)*, with each corresponding MSP Type Code, such as 'working aged', 'End Stage Renal Disease (ESRD)', 'disability', etc.

MEDICARE FISCAL INTERMEDIARIES (FIS)

Until further notice, Medicare Fiscal Intermediaries (FIs) shall continue to submit the HIPAA Individual Relationship Codes, as directed by the National Uniform Billing Committee (NUBC), rather than the CWF Patient Relationship Codes.

MEDICARE PART A CLAIMS PROCESSING CONTRACTORS

Medicare Part A claims processing contractors should update the MSP auxiliary file using the CWF Patient Relationship Code values, rather than using the HIPAA Individual Relationship Codes.

Both the CWF Patient Relationship Codes and the HIPAA Individual Relationship Codes are provided in the following table.

Common Working File (CWF) Patient Relationship Code(s)	Title	Definition	Health Insurance Portability and Accountability Act (HIPAA) Individual Relationship Code(s)
01	Patient is Insured	Self-explanatory.	18
02	Spouse	Self-explanatory.	01
03	Natural Child/Insured Has Financial Responsibility	Self-explanatory.	19
04	Natural Child/Insured Does Not Have Financial Responsibility	Self-explanatory.	43
05	Step Child	Self-explanatory.	17
06	Foster Child	Self-explanatory.	10
07	Ward of the Court	Patient is a ward of the insured as a result of a court order.	15

Common Working File (CWF) Patient Relationship Code(s)	Title	Definition	Health Insurance Portability and Accountability Act (HIPAA) Individual Relationship Code(s)
08	Employee	Patient is employed by the insured.	20
09	Unknown	Patient's relationship to the insured is unknown.	21
10	Handicapped Dependent	Dependent child whose coverage extends beyond normal termination age limits as a result of laws or agreements extending coverage.	22
11	Organ Donor	The bill is submitted for care given to an organ donor where such care is paid by the receiving patient's insurance coverage.	39
12	Cadaver Donor	The bill is submitted for procedures performed on a cadaver donor where such procedures are paid by the receiving patient's insurance coverage.	40
13	Grandchild	Self-explanatory.	05
14	Niece/Nephew	Self-explanatory.	07
15	Injured Plaintiff	Patient is claiming insurance as a result of injury covered by insured.	41
16	Sponsored Dependent	Individual not normally covered by insurance coverage but coverage has been specially arranged to include relationships such as grandparent or former spouse that would require further investigation by the payer.	23

Common Working File (CWF) Patient Relationship Code(s)	Title	Definition	Health Insurance Portability and Accountability Act (HIPAA) Individual Relationship Code(s)
17	Minor Dependent of a Minor Dependent	Patient is a minor and a dependent of another minor who in turn is a dependent (although not a child) of the insured.	24
18	Parent	Self-explanatory.	32, 33
19	Grandparent	Self-explanatory.	04
20	Life Partner*	Patient is covered under an insurance policy of his/her life partner (or similar designation such as a domestic partner, significant other).	53
N/A	Significant Other*		29
22-99		Reserved for National Assignment.	None

* There is no 1:1 mapping for Significant Other and Life Partner.

REFERENCE H: OCCURRENCE AND OCCURRENCE SPAN CODES

The following Occurrence and Occurrence Span Codes are approved for use on Form CMS-1450 (UB-92) in Field Locator (FL)/Block 32-36).

OCCURRENCE CODES

Code	Title	Definition of Associated Date
01	Accident/Medical Coverage	Indicates an accident related injury for which there is medical payment coverage. Provide the date of accident/injury.
02	No-Fault Insurance Involved - Including Auto Accident/Other	Date of an accident, including auto or other, where the state has applicable no-fault or liability laws (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/Tort Liability (Non-automobile Accident)	Date of an accident (excluding automobile) resulting from a third party's action. (Auto accidents are covered by Codes 01 and 02 above.) This incident may involve a civil court action in an attempt to require payment by the third-party, other than no-fault liability.
04	Accident/Employment-Related	Date of an accident that relates to the patient's employment.
05	Accident/No Medical or Liability Coverage	Indicates an accident related injury for which there is no medical payment or third-party liability coverage. Provide the date of the accident or injury.
06	Crime Victim	Indicate the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
07-08	Reserved for National Assignment	Self-explanatory.
09	Start of Infertility Treatment Cycle	Indicates the date of the start of the infertility treatment cycle.
10	Last Menstrual Period (Only applies when patient is being treated for a maternity- related condition.)	The associated date indicates the date of the last menstrual period.
11	Onset of Symptoms/Illness (Outpatient Claims Only)	Date that the patient first became aware of symptoms/illness.

Code	Title	Definition of Associated Date
12	Date of Onset for a Chronically Dependent Individual (CDI) [Home Health Agency (HHA) Claims Only]	The provider enters the date that the patient/beneficiary becomes a chronically dependent individual (CDI). This is the first month of the 3-month period immediately prior to eligibility under Respite Care Benefit.
13-15	Reserved for National Assignment	Self-explanatory.
16	Date of Last Therapy	Code indicates the last day of therapy services (e.g., physical, occupational, or speech therapy). The date indicates when the last therapy session occurred.
17	Date Outpatient Occupational Therapy Plan Established or Reviewed	The date indicates when the occupational therapy plan was established or last reviewed.
18	Date of Retirement Patient/Beneficiary	The date indicates when retirement began for the patient/beneficiary.
19	Date of Retirement Spouse	The date indicates when retirement began for the patient's spouse.
20	Guarantee of Payment Began (Part A Hospital Only)	**Not used on Part B claims.**
21	UR Notice Received [Part A Skilled Nursing Facility (SNF) Only]	**Not used on Part B claims.**
22	Date Active Care Ended [Part A Skilled Nursing Facility (SNF) Only]	**Not used on Part B claims.**
23	Cancellation of Hospice Election Period [Fiscal Intermediary (FI) Use Only]	Code indicates date on which a hospice period of election is cancelled by an intermediary as opposed to revocation by the beneficiary.
24	Date Insurance Denied	Date of receipt of a denial of coverage by a higher priority payer.
25	Date Benefits Terminated by Primary Payer	The date on which coverage [including Workers' Compensation (WC) benefits or no-fault coverage] is no longer available to the patient.
26	Date Skilled Nursing Facility (SNF) Bed Available	**Not used on Part B claims.**

Code	Title	Definition of Associated Date
27	Date of Hospice Certification or Re-Certification	The date of certification or re-certification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods.
28	Date Comprehensive Outpatient Rehabilitation Facility (CORF) Plan Established or Last Reviewed	The date a plan of treatment was established or last reviewed for CORF care.
29	Date Outpatient Physical Therapy (OPT) Plan Established or Last Reviewed	The date a plan was established or last reviewed for OPT.
30	Date Outpatient Speech Pathology Plan Established or Last Reviewed	The date a plan was established or last reviewed for outpatient speech pathology.
31	Date Beneficiary Notified of Intent to Bill (Accommodations)	**Not used on Part B claims.**
32	Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)	The date of the notice provided to the beneficiary that requested care (diagnostic procedures or treatments) that may not be reasonable or necessary under Medicare.
33	First Day of the Medicare Coordination Period for End Stage Renal Dialysis (ESRD) Beneficiaries Covered by an Employee Group Health Plan (EGHP)	The date is the first day of the Medicare coordination period during which Medicare benefits are secondary to benefits payable under an EGHP. This is required only for ESRD beneficiaries.
34	Date of Election of Extended Care Services (Religious Non-Medical Health Care Institutions Only)	**Not used on Part B claims.**
35	Date Treatment Started for Physical Therapy	The date the provider initiated services for physical therapy.
36	Date of Inpatient Hospital Discharge for a Covered Transplant Procedure(s)	The date of discharge for a hospital stay in which the patient received a covered transplant procedure. The code and date are entered on bills for which the hospital is billing for immunosuppressive drugs. **NOTE:** When the patient receives a covered and a non-covered transplant, the covered transplant predominates.

Code	Title	Definition of Associated Date
37	Date of Inpatient Hospital Discharge - Patient Received Non-covered Transplant	The date of discharge for an inpatient hospital stay during which the patient received a non-covered transplant procedure. The code and associated date are entered on bills for which the hospital is billing for immunosuppressive drugs.
38	Date Treatment Started for Home IV Therapy	Date the patient was first treated at home for IV therapy. (Home IV providers - bill type 85X.)
39	Date Discharged on a Continuous Course of IV Therapy	The date the patient was discharged from the hospital on a continuous course of IV therapy. (Home IV providers - bill type 85X.)
40	Scheduled Date of Admission (Outpatient Claim Only)	The date on which a patient will be admitted as an inpatient to the hospital.
41	Date of First Test for Pre-Admission Testing (PAT)	The date on which the first outpatient diagnostic test was performed as a part of a PAT program. This code may be used only if a date of admission was scheduled prior to the administration of the test(s).
42	Termination of Hospice Care	The date the patient's hospice ends. Hospice care may be terminated by a change in the hospice election to another hospice, a revocation of the hospice election, or death.
43	Scheduled Date of Cancelled Surgery	The date for which ambulatory (i.e., outpatient) surgery was scheduled.
44	Date Treatment Started for Occupational Therapy	The date the provider initiated services for occupational therapy.
45	Date Treatment Started for Speech Therapy	The date the provider initiated services for speech therapy.
46	Date Treatment Started for Cardiac Rehabilitation	The date the provider initiated services for cardiac rehabilitation.
47	Date Cost Outlier Status Begins	**Not used on Part B claims.**
48-49	Payer Codes (Third-Party Payers Only)	CMS assigns these codes for FI use. Providers do not report these codes.
50-69	Reserved for State Assignment	Reserved for state assignment. Discontinued effective October 16, 2003.
A1	Birth Date-Insured A	The birth date of the insured in whose name the insurance is carried.

Code	Title	Definition of Associated Date
A2	Effective Date-Insured A Policy	The first date the insurance is in force.
A3	Benefits Exhausted	**Not used on Part B claims.**
A4	Split Bill Date	**Not used on Part B claims.**
A5-AZ	Reserved for National Assignment	Self-explanatory.
B1	Birth Date-Insured B	The birth date of the individual in whose name the insurance is carried.
B2	Effective Date-Insured B Policy	The first date the insurance is in force.
B3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made by payer B.
B4-BZ	Reserved for National Assignment	Self-explanatory.
C1	Birth Date-Insured C	The birth date of the individual in whose name the insurance is carried.
C2	Effective Date-Insured C Policy	The first date the insurance is in force.
C3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made by payer C.
C4-CZ	Reserved for National Assignment	Self-explanatory.
D0-DZ	Reserved for National Assignment	Self-explanatory.
E0	Reserved for National Assignment	Self-explanatory.
E1	Birth Date-Insured D	The birth date of the individual in whose name the insurance is carried.
E2	Effective Date-Insured D Policy	A code indicating the first date insurance is in force.
E3	Benefits Exhausted	Code indicating the last date for which benefits are available and after which no payment can be made to payer D.
E4-EZ	Reserved for National Assignment	Self-explanatory.
F0	Reserved for National Assignment	Self-explanatory.
F1	Birth Date-Insured E	The birth date of the individual in whose name the insurance is carried.
F2	Effective Date-Insured E Policy	A code indicating the first date insurance is in force.

Code	Title	Definition of Associated Date
F3	Benefits Exhausted	Code indicating the last date for which benefits are available and after which no payment can be made to payer E.
F4-FZ	Reserved for National Assignment	Self-explanatory.
G0	Reserved for National Assignment	Self-explanatory.
G1	Birth Date-Insured F	The birth date of the individual in whose name the insurance is carried.
G2	Effective Date-Insured F Policy	A code indicating the first date insurance is in force.
G3	Benefits Exhausted	Code indicating the last date for which benefits are available and after which no payment can be made to payer F.
G4-GZ	Reserved for National Assignment	Self-explanatory.
H0-HZ	Reserved for National Assignment	Self-explanatory.
J0-JZ	Reserved for State Assignment	Reserved for state assignment. Discontinued effective October 16, 2003.

OCCURRENCE SPAN CODES

Code	Title	Definition of Associated Date
70	Qualifying Stay Dates [Part A Claims for Skilled Nursing Facility (SNF) Level of Care Only]	**Not used on Part B claims.**
70	Non-utilization Dates (For Payer Use on Hospital Bills Only)	**Not used on Part B claims.**
71	Hospital Prior Stay Dates (Part A Claims Only)	**Not used on Part B claims.**
72	First/Last Visit	The actual dates of the first and last visits occurring in this billing period where these dates are different from those in Field Locator (FL)/Block 6, Statement Covers Period.

Code	Title	Definition of Associated Date
74	Non-Covered Level of Care	The From/Through dates for a period at a non-covered level of care in an otherwise covered stay, excluding any period reported with Occurrence Span Codes 76, 77, or 79. Codes 76 and 77 apply to most non-covered care. Used for leave of absence or for repetitive Part B services to show a period of inpatient hospital care or outpatient surgery during the billing period. Also used for Home Health Agency (HHA) or hospice services billed under Part A, but not valid for HHA under Prospective Payment System (PPS).
75	Skilled Nursing Facility (SNF) Level of Care	**Not used on Part B claims.**
76	Patient Liability	The From/Through dates for a period of non-covered care for which the provider is permitted to charge the beneficiary. Codes should be used only where the Fiscal Intermediary (FI) or the Quality Improvement Organization (QIO) has approved such charges in advance and the patient has been notified in writing three days prior to the "From" date of this period (see Occurrence Codes 31 and/or 32).
77	Provider Liability - Utilization Charged	The From/Through dates of a period of care for which the provider is liable (other than for lack of medical necessity or custodial care). The beneficiary's record is charged with Part A days, Part A or Part B deductible and Part B coinsurance. The provider may collect the Part A or Part B deductible and coinsurance from the beneficiary.
78	Skilled Nursing Facility (SNF) Prior Stay Dates (Part A Claims Only)	**Not used on Part B claims.**
79	Payer Code	This code is set aside for payer use only. Providers **do not** report this code.
M0	Quality Improvement Organization (QIO)/Utilization Review (UR) Stay Dates	**Not used on Part B claims.**

Code	Title	Definition of Associated Date
M1	Provider Liability-No Utilization	Indicates the From/Through dates of a period of non-covered care that is denied due to lack of medical necessity or as custodial care for which the provider is liable. The beneficiary is not charged with utilization. The provider may not collect Part A or Part B deductible or coinsurance from the beneficiary.
M2	Dates of Inpatient Respite Care	From/Through dates of a period of inpatient respite care for hospice patients.
M3	Intermediate Care Facility (ICF) Level of Care	**Not used on Part B claims.**
M4	Residential Level of Care	**Not used on Part B claims.**
M5-WZ	Reserved for National Assignment	Self-explanatory.
X0-ZZ	Reserved for State Assignment	Reserved for state assignment. Discontinued, effective October 16, 2003.

REFERENCE I: GLOSSARY

A

Aberrancy - medical services that deviate from what is considered normal or typical when compared to the national average.

Abuse - describes practices that either directly or indirectly result in unnecessary costs to the Medicare Program. Many times abuse appears quite similar to fraud except that it is not possible to establish that abusive acts were committed knowingly, willfully, and intentionally. Although these types of practices may initially be categorized as *abusive* in nature, under certain circumstances they may develop into *fraud* if there is evidence the subject was knowingly and willfully conducting an abusive practice.

Act - refers to the term for legislation that passed through Congress and was signed by the President or passed over the President's veto. For the purpose of this document, usually refers to the Social Security Act.

Additional Development Request (ADR) Letter - a notice from Medicare that a claim submitted by a provider organization cannot be processed without additional information/documentation. The letter identifies the additional information needed and the date by which the information must be received by Medicare.

Adjudication - the process of determining whether a Medicare claim is paid or denied based on the information submitted and the eligibility of the recipient.

Adjustment - an additional payment or correction of records on a previously processed claim.

Administrative Law Judge (ALJ) - hears appeals of denied claims, as well as appeals from proposed Office of Inspector General (OIG) exclusions.

Admission - entry to a hospital or other health care institution as an inpatient.

Advance Beneficiary Notice (ABN) - a written notice a provider, practitioner, physician, or supplier gives to a Medicare beneficiary before items or services are furnished when they believe that Medicare probably or certainly will not pay for some or all of the items or services on the basis that the items or services are defined within the Social Security Act as "not reasonable and necessary" (Section 1862(a)(1)); are "custodial care" (Section 1862(a)(9)); or are denied coverage because the beneficiary is not "homebound", does not need intermitted skilled nursing services, or is not terminally ill (Section 1879(g)).

ABNs are designed for use with Medicare beneficiaries only and allow beneficiaries to have a greater role in their own health care treatment decisions. ABNs provide beneficiaries with the opportunity to make informed consumer decisions as to whether they want to receive items and/or services for which they may be personally and fully responsible, either out of their own pocket, or through other insurance they may have. The failure to properly deliver an ABN in situations where one is required may result in the provider, practitioner, physician, or supplier being held financially liable, unless they can show that they did not know and could not reasonably have been expected to know that Medicare would deny payment. To be acceptable, an ABN must be on the approved Forms and clearly identify the particular item or service for which the notice is being provided, and

must clearly state the reason that the provider, practitioner, physician, or supplier believes Medicare probably or certainly will not pay for the item or service.

Advanced Registered Nurse Practitioner (ARNP) - a Registered Nurse (RN) who has advanced education and clinical training in a health care specialty area.

Aged Insured - describes a person age 65 or older who meets the qualifications for Medicare coverage.

Aggrieved Party - a Medicare beneficiary (or estate) who meets the requirements to challenge the validity of a Local Coverage Determination (LCD) or an National Coverage Determination (NCD) by submitting a request for review of the policy.

Ambulatory Surgical Center (ASC) - a freestanding facility, other than a hospital or physician's office, where outpatient surgical and diagnostic services are provided. At an ambulatory (in and out) surgery center, the beneficiary may stay for only a few hours or for one night.

American Medical Association (AMA) - a national association that develops and promotes medical practice, research, and education on behalf of patients and physicians.

American National Standard Institute (ANSI) Format - an electronic format used to submit Medicare Part B claim forms to Medicare for payment.

Ancillary Services - professional services provided by a hospital or other inpatient health program, other than room, board, and surgery (e.g., laboratory, X-ray, drugs).

Anti-Kickback Statute - a federal statute outlawing certain forms of discounts, rebates, and other reductions in price, inducing the purchase of items or services payable by Medicare or Medicaid.

Appeal - the right for an independent, critical examination of a claim. The five levels of appeal permitted for claims denied by Carriers include: a *review* made by Carrier personnel not involved in the initial claim determination; a *Hearing Officer (HO) hearing*; an *Administrative Law Judge (ALJ) hearing*; a *Department Appeals Board (DAB) hearing*; and a review by a United States District Court judge. A request for a review may be made to the local Medicare Carrier by telephone or in writing. Physicians, beneficiaries or their representatives, providers or other suppliers, may request appeals or reviews.

Appellant - an individual who appeals a claim decision.

Approved Amount/Charge - the fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by the beneficiary and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier.

Assigned Claim - a claim submitted to Medicare by a Part B provider who agrees to accept the Medicare-approved charges as payment in full for the rendered service.

Assignment - a physician, provider, or supplier agrees to accept the Medicare fee schedule amount as payment in full for the rendered services.

Audit - a process to ensure that Medicare reimburses providers based only on costs associated with patient care.

B

Balance Billing/Excess Charge - the difference between the billed amount and the amount allowed by Medicare.

Balanced Budget Act of 1997 (BBA) - the law that changes sections of the Social Security Act, including several anti-fraud and abuse provisions and improvements to protect program integrity.

Beneficiary - an individual who is entitled to receive Medicare or Medicaid payment and/or services.

Benefit Period - the measure of a Medicare beneficiary's use of hospital and Skilled Nursing Facility (SNF) services.

Billed Amount - the amount charged for each service performed by the provider.

Billing Service - a company that, for a fee, furnishes billing, collection, and/or claim filing services for physicians and/or suppliers.

Blue Cross and Blue Shield Association (BCBSA) - non-profit corporation representing the Blue Cross and Blue Shield plans on a national level as a coordinating agency in marketing, Government relations, and other system wide initiatives; owns the Blue Cross Blue Shield mark and sets approval standards.

Business Associate - an individual such as a contractor or supplier who is associated with an employer in a business relationship.

C

Calendar Year (CY) - the period of January 1st through December 31st.

Capitation Rate - the fixed amount that Centers for Medicare & Medicaid Services (CMS) pays to an approved managed care plan selected by an enrolled Medicare beneficiary.

Carrier - a contractor for the Centers for Medicare & Medicaid Services (CMS) that determines reasonable charges, accuracy, and coverage for Medicare Part B services and processes Part B claims and payments.

Carrier Advisory Committee (CAC) - a formal mechanism for physicians to be informed of and participate in the development of a Local Coverage Determination (LCD) process in an advisory capacity. This group also discusses ways to improve administrative policies that are within Carrier discretion.

Centers for Medicare & Medicaid Services (CMS) - the Department of Health and Human Services (HHS) agency responsible for Medicare and parts of Medicaid. Centers for Medicare & Medicaid Services has historically maintained the UB-92 institutional Electronic Media Claims (EMC) format specifications, the professional EMC National Standard Format (NSF) specifications, and specifications for various certifications and authorizations used by the Medicare and Medicaid programs. CMS is responsible for oversight of Health Insurance Portability and Accountability Act of 1996 (HIPAA) administrative simplification transaction and code sets, health identifiers, and security standards. CMS also maintains the Healthcare Common Procedure Coding System (HCPCS) medical code set and the Medicare Remittance Advice Remark Codes administrative code set. CMS

is the division of HHS that administers Medicare and works with state departments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards.

Certificate of Medical Necessity (CMN) - certain Medicare-covered services such as ambulance, cataract glasses, Durable Medical Equipment (DME), and other services require a signed physician's Statement authenticating that the items or services were medically necessary.

Certified Provider - a physician, other individual, or entity meeting certain quality standards that provides outpatient self-management training services and other Medicare covered items and services.

Claim - a request for payment of Medicare benefits or services rendered by a provider or received by a beneficiary.

Clearinghouse - an organization, usually national, that, for a fee, receives and sorts provider claims and forwards them to the correct Medicare Contractor or commercial insurer.

Clear Policy - a statute, regulation, National Coverage Determination (NCD), or coverage provision in an interpretive manual, or Local Coverage Determination (LCD) that specifies the circumstances under which a service will always be considered non-covered or incorrectly coded. Clear policy that will be used as the basis for frequency denials must contain utilization guidelines that the contractor considers acceptable for coverage.

Clinical Laboratory Improvement Amendments (CLIA) - legislation passed in 1988 that set quality and performance standards for all laboratory testing. CLIA standards are national and are not Medicare-exclusive. CLIA applies to all providers rendering clinical laboratory and certain other diagnostic services, whether or not claims are filed to Medicare.

Coinsurance Amount - the amount that Medicare will not pay; the beneficiary or the beneficiary's supplemental insurance company is responsible for paying coinsurance to the physician.

Community Mental Health Center (CMHC) - a facility that provides outpatient mental health services to individuals residing within a specific geographic area.

Concurrent Care - certain emergency/medical services that are rendered by more than one physician with the same or similar specialty on the same date of service.

Consultation - examination by an additional physician or specialist, at the request of a referring physician, the patient, or the patient's family.

Contractor - a state or private health insurer that processes Medicare claims and makes payments to providers of services and to beneficiaries. See also Carrier, Durable Medical Equipment Regional Carrier (DMERC), and Fiscal Intermediary.

Copayment - in some Medicare health plans, the amount that is paid by the beneficiary for each medical service, like a doctor's visit. A copayment is usually a set amount paid for a service. For example, this could be $10 or $20 for a doctor's visit. Copayments are also used for some hospital outpatient services in the Medicare Plan.

Coordination of Benefits (COB) - the Centers for Medicare & Medicaid Services (CMS) COB Program helps identify beneficiary health care coverage that should pay primary to Medicare. The COB Contractor supports the collection management and reporting of other insurance coverage so that beneficiary health care expenses are properly paid while protecting the Medicare Trust Fund assets.

Coverage - describes what items and services are payable by a health insurance plan.

Coverage Provisions in Interpretive Manuals - national coverage instructions published by the Centers for Medicaid & Medicare Services (CMS) that are not considered to be National Coverage Determinations (NCDs). They are used to further define when, and under what circumstances, services may be covered or not covered under Medicare. Once published, they are binding on all providers.

Covered Services - reasonable and medically necessary services, rendered to Medicare or Medicaid patients, and reimbursable to the provider or beneficiary.

Critical Access Hospital (CAH) - a small facility that gives limited outpatient and inpatient hospital services to individuals in rural areas; established as part of the Balanced Budget Act Medicare Rural Hospital Flexibility Program to replace the Essential Access Community and Rural Primary Care Hospital Programs.

Crossover Claims - Medicare claims that are also covered by other insurance (e.g., Medigap, private insurance).

Current Procedural Terminology (CPT) - a medical code set of physician and other services, maintained and copyrighted by the American Medical Association (AMA), and adopted by the Secretary of the Department of Health and Human Services (HHS) as the standard for reporting physician and other services on standard transactions.

D

Date of Service - the date a service was actually performed.

Decisions/Determinations - if a Medicare appeal request does not result in a dismissal, adjudication of the appeal results in either a “determination” or “decision”. There is no apparent practical distinction between these two terms, although applicable regulations use the terms in distinct context. Medicare regulations use the term “determination” in the following appeals contexts: Initial determination; reconsideration or review determination; limitation on liability determination; and provider, physician or supplier refund determination. A determination that is reopened and thereafter revised is called a “revised determination”. Medicare regulations use the term “decision” in the following appeals contexts: Hearing Officer (HO) hearing decision; Administrative Law Judge (ALJ) hearing decision; Departmental Appeals Board decision; and administrator decision. A decision that is reopened and thereafter revised is called a “revised decision”.

Deductible - amount a beneficiary must pay for health care before Medicare begins to pay either for each benefit period for Part A or each year for Part B. These amounts can change every year.

Denial - non-payment of a processed claim for an identified technical or medical necessity reason.

Department of Health and Human Services (HHS) - the United States Government's principal agency for providing essential human services. HHS includes more than 300 programs, including Medicare, Medicaid, and the Centers for Disease Control and Prevention (CDC). HHS administers many of the "social" programs at the federal level dealing with the health and welfare of the citizens of the United States. [It is the "parent" of the Centers for Medicare & Medicaid Services (CMS).]

Diabetes Self-Management Training (DSMT) Services - a program intended to educate beneficiaries in the successful self-management of diabetes. The program includes:

- Instructions in self-monitoring of blood glucose
- Education about diet and exercise
- An insulin treatment plan developed specifically for insulin dependent beneficiaries
- Motivation for beneficiaries to use the skills for self-management

Diagnosis - an identification of the patient's condition, cause, or disease.

Diagnosis Code - the first of these codes is the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing this hospitalization). The remaining codes are the ICD-9-CM diagnosis codes corresponding to additional conditions that coexisted at the time of admission, or developed subsequently, and which had an effect on the treatment received or the length of stay.

Diagnosis Related Group (DRG) - a classification system that groups patients according to principal diagnosis, type of treatment, age, and other relevant criteria. Under the Prospective Payment System (PPS), hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual.

Disabled Insured - describes a person under age 65 (and some family members) who meet the qualifications for Medicare coverage related to the disability.

Dismissal - a request for appeal may be dismissed for any number of reasons, including: Abandonment of the appeal by the appellant; a request is made by the appellant to withdraw the appeal; an appellant is determined to not be a proper part; the amount in controversy requirements have not been met; or the appellant has died and no one else is prejudiced by the claims determination. A dismissal of a request for review may not be appealed. A Hearing Officer (HO) dismissal may not be appealed. An HO dismissal may not be appealed, however, for good cause shown, an HO may vacate (i.e., set aside or rescind) his or her order of dismissal within 6 months of the date of the dismissal. An Administrative Law Judge's (ALJ's) dismissal may be vacated by the ALJ or the Departmental Appeals Board for good cause within 60 days after the date of receipt of the dismissal notice.

Documentation Guidelines - prescribe the correct use of Evaluation and Management Service (E/M) codes used by all types of physicians.

Duplicate Claims - billing for the same service more than once; Medicare may remove physicians who repeatedly submit duplicate claims from the electronic billing network.

Durable Medical Equipment (DME) - medical equipment that is ordered by a doctor (or, if Medicare allows, a nurse practitioner, physician assistant, or clinical nurse specialist) for use in the home. A hospital or nursing home that mostly provides skilled care cannot qualify as a "home" in this situation. These items must be reusable, such as walkers, wheelchairs, or hospital beds. DME is paid for under both Medicare Part B and Part A for home health services.

Durable Medical Equipment Regional Carrier (DMERC) - a contractor for the Centers for Medicare & Medicaid Services (CMS) that provides Medicare claims processing and payment of Durable Medical Equipment (DME), prosthetics, orthotics, and supplies for a designated region of the country.

E

Electronic Funds Transfer (EFT) - an electronic transfer of Medicare payments directly to a provider's financial institution.

Electronic Media Claims (EMC) - the transmission of claims via modem to the contractor, eliminating mailroom processing and manual data entry; payment is released when CMS time requirements are satisfied, resulting in a faster cash flow turnaround for providers.

Electronic Remittance Advice (ERA) - an electronic summarized Statement for providers, including payment information for one or more beneficiaries; equivalent to the Medicare Remittance Notice (MRN); see also Medicare Remittance Advice.

Eligible - a term used to describe a person who is qualified to receive Medicare benefits.

Eligibility Date - starting date that Medicare benefits are available.

Emergency - a situation in which a patient requires immediate medical intervention as a result of severe, life-threatening, or potentially disabling conditions.

End Stage Renal Disease (ESRD) - kidney failure that is severe enough to require lifetime dialysis or a kidney transplant.

End Stage Renal Disease (ESRD) Insured - describes a person who could be under age 65 who meets the qualifications for Medicare coverage related to ESRD.

Enrollment - the means by which a person establishes membership in a program or group.

Entitlement - state of meeting all of the requirements for a particular Medicare benefit; the date of entitlement begins at age 65 for most beneficiaries.

Episode of Care - an identified period from the onset to the conclusion of treatment or a payment period. In Medicare, payments for some providers such as hospitals and home health agencies are based upon episodes.

Evaluation & Management Service (E/M) Codes - used by all physicians to explain how the physician gathered and analyzed information about a patient's illness, determined a condition, and devised the best treatment or course of treatment. These codes are a subset of the Current Procedural Terminology (CPT) code set.

Excess Charge - see Balance Billing.

Exclusion - a situation or condition where coverage is disallowed by a subscriber's contract; Department of Health and Human Services (HHS)/Office of Inspector General (OIG) penalty imposed on a provider, prohibiting the individual from billing Medicare or other Government programs.

Exclusion List/Sanctioned Provider List - an Office of Inspector General (OIG) list of providers, individuals, and entities that are excluded from Medicare reimbursement; includes identifying information about the sanctioned party, specialty, notice date, sanction period, and sections of the Social Security Act used in arriving at the determination to impose a sanction.

Experimental/Investigative - any treatment, procedure, equipment, drug, drug usage, device, or supply not generally recognized as accepted medical practice; includes services or supplies requiring federal or other Government approval not granted at the time services were rendered.

F

Fee-for-Service - a payment system where providers are paid a specific amount for each service rendered.

Fee Schedule - see Medicare Physician Fee Schedule.

Fiscal Intermediary (FI) - a contractor for the Centers for Medicare & Medicaid Services (CMS) who determines reasonable charges, accuracy, and coverage for Medicare and processes claims and payments.

Fiscal Year (FY) - October 1st through September 30th for Medicare Part A and B.

Fraud - the intentional deception or misrepresentation that an individual knows or should know to be false or does not believe to be true, and makes, knowing that the deception could result in some unauthorized benefit to himself or herself or some other person(s).

G

Gap - see Medicare Gap.

Group Health Plan (GHP) - a health insurance plan sponsored by either a patient's or the spouse of a patient's employer where a single employer of 20 or more employees is the sponsor and/or contributor to the GHP, or two or more employers are sponsors and/or contributors and at least one of them has 20 or more employees.

H

Health Care Claims Adjustment Reason Code - a national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's payment for it. This code set is maintained by the Health Care Code Maintenance Committee.

Health Care Common Procedure Coding System (HCPCS) - a uniform method for providers and suppliers to report professional services, procedures, and supplies. HCPCS includes Current

Procedure Technology (CPT) codes (Level I), national alphanumeric codes (Level II), and local codes (Level III) assigned and maintained by local Medicare Contractors.

Health Insurance Claim Number (HIC/HICN) - a unique 10 or 11-digit alphanumeric Medicare entitlement number assigned to a Medicare beneficiary; appears on the Medicare Health Insurance card.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) - a law passed in 1996. The Centers for Medicare & Medicaid Services (CMS) is responsible for implementing various unrelated provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), therefore HIPAA may mean different things to different people. Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. The Administrative Simplification provisions of HIPAA Title II require the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers.

Health Maintenance Organization (HMO) - a form of health insurance that combines a range of coverage on a group basis; a group of doctors and other medical professionals offer care through the HMO for a flat monthly rate with no deductibles; only visits to professionals within the HMO network are covered by the policy, all visits; prescriptions and other care must be cleared by the HMO to be covered.

Health Professional Shortage Area (HPSA) - a medically under-served area of a state where physicians receive a 10% bonus payment for all professional physician services [i.e., services subject to the Medicare Physician Fee Schedule (MPFS)].

Hearing Officer (HO) Hearing - an independent determination related to claims where a party has appealed a review decision within 6 months of the date of notice of the review decision; hearing is rendered by a Hearing Officer (HO) assigned by the contractor; amount in controversy (AIC) must be at least $100, which can include more than one claim.

Home Health Agency (HHA) - a public or private organization that specializes in giving in-home care services, such as skilled nursing, physical therapy, occupational therapy, speech therapy, and care by home health aides.

Homebound - a patient normally unable to leave home; leaving home takes considerable and taxing effort; patient may leave home for medical treatment or short, infrequent absences for non-medical reasons such as a trip to the barber.

Home Health Care - limited part-time health care services provided in the home for the treatment of an illness or injury. Medicare pays for home care only if the type of care needed is skilled and required on an intermittent basis and is intended to help individuals recover or improve from an illness, not to provide unskilled services over a long period of time.

Hospice - a facility providing pain relief, symptom management, and supportive services to terminally ill people and their families; eligible beneficiary must have a life expectancy of 6 months or less. Hospice care is covered under Medicare Part A (Hospital Insurance).

Hospital - an institution with organized medical staff, permanent facilities that include inpatient beds, medical services including physician services and continuous nursing services, to provide diagnosis and treatment for patients with a variety of medical conditions, both surgical and non-surgical.

I

"Incident to" Services - services rendered by employees of physicians or physician-directed clinics, when the services provided are integral, though incidental, to the physician's professional service and are performed under direct supervision of the physician.

Initial Preventive Physical Examination (IPPE) - a comprehensive physical examination provided by Medicare to assess risk factors for disease. Also called the "Welcome to Medicare" Physical Exam, the exam is available to all beneficiaries who begin their Medicare coverage on or after January 1, 2005, and must be provided within the first six months of coverage. It is the Initial Preventive Physical Examination (IPPE) or the "Welcome to Medicare" Physical Exam or visit.

Individual Health Care Practitioner - any physician or non-physician who renders services to Medicare beneficiaries and submits claims to Carriers for services rendered. Form CMS-855I is required for enrollment.

Inpatient - an individual who has been admitted at least overnight to a hospital or other health facility for the purpose of receiving a diagnosis, treatment, or other health service.

Inquiry - a written request for information, usually pertaining to claim status or general information, such as deductible or entitlement.

Institutions - Medicare providers such as hospital, Skilled Nursing Facilities (SNFs), and Comprehensive Outpatient Rehabilitation Facilities (CORFs) that submit claims to Fiscal Intermediaries (FIs).

International Classification of Diseases (ICD) - a medical code set maintained by the World Health Organization (WHO). The primary purpose of this code set was to classify causes of death. A United States extension, maintained by the National Centers for Health Statistics (NCHS) within the Centers for Disease Control and Prevention (CDC), identifies morbidity factors or diagnoses. The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes have been selected for use in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) transactions.

Investigative/Experimental - any treatment, procedure, equipment, drug, drug usage, device, or supply not generally recognized as accepted medical practice; includes services or supplies requiring federal or other Government approval not granted at the time services were rendered.

J

Judicial Review - part of the Medicare appeals process; if at least $1,000 remains in controversy following the Departmental Appeals Board (DAB) decision, judicial review before a United States District Court judge can be considered.

K

Kickback - offering, soliciting, paying, or receiving remuneration for *referrals* of Medicare or Medicaid patients, or for referrals for services or items paid for, in whole or in part, by Medicare or Medicaid; prohibited by the Anti-Kickback Statue.

L

Large Group Health Plan (LGHP) - a health insurance plan which is contributed to by an employer or employee organization having 100 or more employees, or a plan having a least one member which has at least 100 employees.

Licensed Physician - a physician who is authorized to perform services within limitations imposed by the state on the scope of practice; issuance by a state of a license to practice medicine constitutes legal authorization; see also Physician.

Local Coverage Determination (LCD) - local coverage policy developed by Fiscal Intermediaries (FIs) and Carriers to describe the circumstances for Medicare coverage for a specific medical service procedure or device within their jurisdiction.

Long-term Care - custodial care given at home or in a nursing home for people with chronic disabilities and lengthy illnesses; not covered by Medicare.

M

Managed Care Plan - a system of providing health care that is designed to control costs through managed care programs in which the physician accepts constraints on the amount charged for medical care and the patient is limited in the choice of a physician [e.g., Health Maintenance Organization (HMO), Preferred Provider Organization (PPO)].

Medicaid - federal/state entitlement program under Title XIX of the Social Security Act that pays for medical assistance for certain individuals and families with low incomes and resources; policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity.

Medically Necessary Services - services or supplies that are proper and needed for the diagnosis or treatment of an illness or injury, meet standards of good medical practice, and are not provided for the convenience of the patient or the doctor.

Medical Review (MR) - a review of services by contractor medical personnel; includes analysis of claims data to identify potential billing problems resulting in inappropriate utilization situations; includes various plans of action to correct the problem.

Medicare - a federal health insurance program established by Congress through Title XVIII of the Social Security Act (July 1, 1966) that provides medical coverage for people 65 or older, certain disabled individuals, and most individuals with End Stage Renal Disease (ESRD).

Medicare Administrative Contractor (MAC) - the new contracting organization that is responsible for the receipt, processing, and payment of Medicare claims. In addition to providing core claims processing operations for both Medicare Part A and Part B, they will perform functions related to: Beneficiary and Provider Service, Appeals, Provider Outreach and Education (also referred to as Provider Education and Training), Financial Management, Program Evaluation, Reimbursement, Payment Safeguards, and Information Systems Security.

Medicare Advantage (Formerly Medicare + Choice) - also known as Part C of the Medicare Program; set of health care options created by the Balanced Budget Act of 1997 (BBA); “managed

care" plan; includes Health Maintenance Organization (HMO), Point of Service (POS), Provider Sponsored Organization (PSO), Preferred Provider Organization (PPO), Medical Savings Account (MSA), religious fraternal benefit society plan (RFP), and private fee-for-service plan. Everyone who has Medicare Part A and Part B is eligible, except those who have End Stage Renal Disease (ESRD) (unless certain exceptions apply).

Medicare-certified Provider - a physician, other individual, or entity meeting certain quality standards that provides outpatient self-management training services and other Medicare covered items and services.

Medicare Fee Schedule - the resource-based fee schedule that Medicare utilizes to reimburse/pay for physician, laboratory, and supplier services.

Medicare Gap - the cost(s) or service(s) that are not covered under the Medicare Plan.

Medicare Part A - medical coverage that is generally provided automatically, and free of premiums, to persons age 65 or over who are eligible for Social Security or Railroad Retirement Board (RRB) benefits, whether they have claimed the monthly cash benefits or not, also certain Government employees and certain disabled individuals.

Medicare Part B - provides insurance coverage for services by physicians and medical suppliers to persons age 65 or over who are eligible for Social Security or Railroad Retirement Board (RRB) benefits, whether they have claimed the monthly cash benefits or not, also certain Government employees and certain disabled individuals.

Medicare Part C - also known as Medicare + Choice; a set of heath care options created by the Balanced Budget Act (BBA); "managed care" plan; includes Health Maintenance Organization (HMO), Point of Service (POS), Provider Sponsored Organization (PSO), Preferred Provider Organization (PPO), Medical Savings Account (MSA), religious fraternal benefit society plan (RFP), and private fee-for-service plan.

Medicare Part D - beginning in 2006, will provide beneficiaries with a Medicare drug benefit through private health plans. Anyone enrolled in Medicare Parts A or B will be eligible to join Part D. Beneficiaries will be able to elect to receive prescription drug coverage through either drug-only or a Medicare Advantage Plan that provides comprehensive benefits.

Medicare Physician Fee Schedule (MPFS) - a complete list of medical procedure codes and the maximum dollar amounts Medicare will allow for each service rendered for a beneficiary. MPFS is based on the calculation of several components, including relative value unit (RVU), which is based on three factors: the physician's work; overhead expenses; and malpractice insurance.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) - a comprehensive bill, signed by President George W. Bush on December 8, 2003, that expands many different phases of Medicare and introduces the Medicare-approved drug discount cards. The MMA also expanded the list of Preventive Services covered by Medicare.

Medicare Remittance Notice (MRN) - a paper summarized Statement for providers, including payment information for one or more beneficiaries; equivalent to the Electronic Remittance Advice (ERA); also see Electronic Remittance Notice.

Medicare Secondary Payer (MSP) - the term used when Medicare is not responsible for paying first on a claim; some individuals have other insurance or coverage that must pay before Medicare pays [e.g., Group Health Plan (GHP)].

Medicare Summary Notice (MSN) - a notice sent to a Medicare beneficiary that indicates how Medicare processed the claim (i.e., what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what the beneficiary may pay).

Medicare Trust Fund - a United States Department of Treasury account established by the Social Security Act for the receipt of revenues, maintenance of reserves, and disbursement of payments for the Medicare Program.

Medigap - Medicare supplemental health insurance policies sold by private insurance companies and designed to supplement, or fill “gaps” in, Medicare coverage; such policies usually, but not always, feature coverage of coinsurance amounts and deductibles,

Modifier - a 2-digit alphanumeric code used in conjunction with a procedure code to provide additional information about the service, may affect reimbursement of services.

N

National Coverage Determination (NCD) - national coverage policy developed by the Centers for Medicare & Medicaid Services (CMS) to describe the circumstances for Medicare coverage for a specific medical service, procedure, or device.

National Drug Code - code(s) required by the Health Insurance Portability and Accountability Act (HIPAA) to indicate drugs and biologics used in retail pharmacy transactions.

National Provider Identifier (NPI) - effective May 23, 2005, providers could apply for this 10-digit provider identification number. The NPI will replace all legacy transaction numbers [e.g., Unique Provider Identification Numbers (UPINs), Blue Cross and Blue Shield numbers, CHAMPUS numbers, and Medicaid numbers] in all standardized Medicare transactions.

National Standard Format (NSF) - the standardized electronic format used to submit Medicare Part B claim forms.

Non-Assigned Claim - a type of claim that directs payment to the beneficiary and may only be filed by a non-participating Medicare physician; when a claim is filed non-assigned the beneficiary is reimbursed directly.

Non-Participating Provider - a physician, provider, or supplier who does not agree to accept Medicare’s allowed amount as payment in full and may charge the beneficiary, up to the limiting charge, for the service(s); may accept assignment of Medicare claims on a case-by-case basis.

Non-Physician Practitioner - a health care provider who meets state licensing requirements to provide specific medical services. Medicare allows payment for services furnished by qualified non-physician practitioners, including, but not limited to, Advance Registered Nurse Practitioners (ARNPs), Clinical Nurse Specialists (CNSs), Licensed Clinical Social Workers (LCSWs), Physician Assistants (PAs), nurse midwives, physical therapists, and audiologists.

Normal/Reasonable - applying normal collection processes to Medicare as well as non-Medicare patients.

Notice of Exclusion of Medicare Benefits (NEMB) - a voluntary notice that a provider may furnish to a beneficiary to identify that Medicare will not pay for particular items or services that are not part of the Medicare benefit, before the items or services are furnished to the beneficiary.

O

Occupational Therapy - services provided by a qualified occupational therapy practitioner for therapeutic interventions to improve, sustain, or restore an individual's level of function in performance of activities of daily living and work, including: therapeutic activities, therapeutic exercises; sensorimotor processing; psychosocial skills training; cognitive retraining; fabrication and application of orthotic devices; and training in the use of orthotic and prosthetic devices; adaptation of environments; and application of physical agent modalities.

Office of the Inspector General (OIG) - an organizational component of the Office of the Secretary, Department of Health and Human Services (HHS); responsible for conducting and supervising audits, investigations, and inspections relating to the programs and operations of HHS, including Medicare and Medicaid. OIG provides leadership and coordination, recommends policies and corrective actions, prevents and detects fraud and abuse in HHS programs and operations, and is responsible for all HHS criminal investigations, including Medicare fraud, whether committed by contractors, grantees, beneficiaries, or providers of service.

Open Enrollment Period - the one opportunity each year when physicians may change participation status for the following Calender Year (CY), usually in November.

Optical Character Recognition (OCR) - automated scanning process similar to scanners that read price labels in grocery stores; some contractors use OCR to scan claims information for further processing.

Out-of-Plan Provider - beneficiaries in certain Medicare Advantage Plans require services to be furnished by a provider that is under contract with the plan. If a provider does not have an agreement with the plan, they are considered to be an out-of-plan provider and their services may not be paid for by the plan.

Outpatient - a patient who receives care at a hospital or other health facility without being admitted to the facility; outpatient care also refers to care given in organized programs, such as outpatient clinics.

Overpayment - when Medicare funds that a physician, supplier, or beneficiary has received are in excess of amounts due and payable under Medicare statute and regulations; the amount of the overpayment is a debt owed to the United States Government.

P

Part A - coverage that is generally provided automatically, and free of premiums, to persons age 65 or over who are eligible for Social Security or Railroad Retirement Board (RRB) benefits, whether they have claimed the monthly cash benefits or not, also certain Government employees and certain disabled individuals.

Part B - provides insurance coverage for services by physicians and medical suppliers to persons age 65 or over who are eligible for Social Security or Railroad Retirement Board (RRB) benefits, whether they have claimed the monthly cash benefits or not, also certain Government employees and certain disabled individuals.

Part C - a set of heath care options created by the Balanced Budget Act (BBA); “managed care” plan; includes Health Maintenance Organization (HMO), Point of Service (POS), Provider Sponsored Organization (PSO), Preferred Provider Organization (PPO), Medical Savings Account (MSA), religious fraternal benefit society plan (RFP), and private fee-for-service plan.

Part D - beginning in 2006, will provide beneficiaries with a Medicare drug benefit through private health plans. Anyone enrolled in Medicare Parts A or B will be eligible to join Part D. Beneficiaries will be able to elect to receive prescription drug coverage through either drug-only or a Medicare Advantage Plan that provides comprehensive benefits.

Participating Physician - physician who signs a participation agreement to accept assignment for a specified period of time on all claims submitted to Medicare.

Participation Program - Medicare Program in which a physician voluntarily enters into an agreement to accept assignment for all services provided to Medicare patients.

Patient - a person under treatment or care, by a physician or other individual practitioner, in a hospital or other health care facility.

Physical Therapy - services provided within the scope of physical therapists and necessary for the diagnosis and treatment of impairments, functional limitations, disabilities or changes in physical function and health status.

Physician - an individual licensed under state law to practice medicine or osteopathy.

Physician Assistant (PA) - a specially trained and licensed individual who performs tasks usually done by physicians and works under the direction of a supervising physician.

Physician Associate (PA) Group - a partnership, association, or corporation composed of two or more physicians and/or non-physician practitioners who wish to bill Medicare as a unit.

Place of Service (POS) - the location where a service is performed, such as a hospital (inpatient or outpatient), doctor’s office, or Skilled Nursing Facility (SNF). Also known as Point of Service (POS).

Plan of Care (POC) - a physician’s written plan stating the kind(s) of service(s) and care a beneficiary needs for his or her health problem.

Point of Service (POS) - the location where a service is performed, such as a hospital (inpatient or outpatient), doctor’s office, or Skilled Nursing Facility (SNF). Also known as Place of Service (POS).

Preferred Provider Organization (PPO) - a managed care plan in which the patient uses physicians, hospitals, and providers that belong to a network.

Premium - the amount a beneficiary regularly pays to Medicare, an insurance company, or a health care plan for health care coverage.

Preventive Care - services used to keep a beneficiary healthy or to prevent illness, such as Pap tests, mammograms, prostate and colorectal cancer screenings, and influenza and pneumonia vaccinations.

Primary Payer - the insurer (private or Governmental) that pays first on a claim for medical care.

Prior Authorization - beneficiaries in certain Medicare Advantage Plans require prior approval from the plan for certain services to be paid for by the plan.

Procedure - an established series of steps used to eliminate a health problem or to learn more about it (e.g., surgery, tests, inserting an intravenous line) that is represented by a Procedure Code for payment purposes.

Procedure Code - the alphanumeric representation of a procedure used to determine reimbursement for services rendered on a claim form and other medical documentation. The Health Insurance Portability and Accountability Act (HIPAA) has identified the Current Procedural Terminology (CPT) and Health Care Common Procedure Coding System (HCPCS) as the only procedure code sets permitted in electronic transactions.

Professional Component - a diagnostic test situation where the physician interprets but does not perform the test.

Prognosis - prediction of a probable course of a disease and the chances of recovery.

Progressive Corrective Action (PCA) - a process used to identify and prevent Medicare fraud and abuse that involves data-driven Medical Review (MR) and provider education activities.

Prosecute - to submit a charging document to a court; seek a grand jury indictment against person(s) accused of committing criminal offenses.

Prospective Payment System (PPS) - mandated by the Balanced Budget Act of 1997 (BBA); changes Medicare payments from cost-based to prospective, based on national average capital costs per case. PPS helps Medicare control its spending by encouraging providers to furnish care that is efficient, appropriate, and typical of practice expenses for providers. Patients and resource needs are statistically grouped, and the system is adjusted for patient characteristics that affect the cost of providing care. A unit of service is then established, with a fixed, predetermined amount for payment.

Provider - any Medicare provider (e.g., hospital, Skilled Nursing Facility (SNF), Home Health Agency (HHA), Outpatient Physical Therapy (OPT), Comprehensive Outpatient Rehabilitation Facility (CORF), End Stage Renal Disease (ESRD) facility/Renal Dialysis Facility (RDF), hospice, physician, qualified non-physician provider, laboratory, supplier, etc.) providing medical services covered under Medicare Part B.

Provider Identification Number (PIN) - a unique individual billing number issued to a provider by the local Medicare Contractor, allowing the physician or patient to receive reimbursement for claims filed to the contractor.

Purchased Diagnostic Test - a test, such as an electrocardiogram (EKG), X-ray, or ultrasound, purchased from an outside supplier; the physician does not personally perform or supervise the test.

Q

Quality Improvement Contractor (QIC) - an independent contractor who has been awarded contract(s) to review denied claims for Part A, Part B, or Durable Medical Equipment (DME) within the specific geographical area of the United States for which the QIC will process claims appeals.

Quality Improvement Organization (QIO) - organization contracting with the Centers for Medicare & Medicaid Services (CMS) to review medical necessity and quality of care provided to Medicare beneficiaries

Quality Assurance (QA) - process of determining how well a medical service is provided. The QA process may include formal review of health care provided, locating and correcting any problems, and verifying that corrections have eliminated the problem(s) found.

Qui Tam - the “Whistle Blower” or “qui tam” provision allows any person having knowledge of a false claim against the Government to bring an action against the suspected wrongdoer on behalf of the United States Government. A person who files a “qui tam” suit on behalf of the Government is known as a “relator” and may share a percentage of the recovery realized from a successful action.

R

Reasonable/Normal - applying normal collection processes to Medicare as well as non-Medicare patients.

Reassignment of Benefit - individual health care practitioners enrolled in a group practice or clinic that bills a Carrier must state that they agree to turn monies over to the group/clinic for services furnished for the group/clinic. Form CMS-855R is required for enrollment.

Reconsideration - for a Fiscal Intermediary (FI), a reconsideration hearing is the second level of appeal for participating providers who are dissatisfied with the outcome of a redetermination. For all FI redeterminations issued on or after May 1, 2005, appellants have the right to reconsideration by a QIC within 180 days of the request for reconsideration.

Redetermination - a second look at an initial determination by a Qualified Independent Contractor (QIC) for a claim that is being contested by a beneficiary or their designee. The QIC reviews the claim and its supporting documentation independently of the reviewers who were originally involved in the initial claim determination.

Referral - specialty, inpatient, outpatient, or laboratory services that are ordered or arranged, but not furnished directly; approval from a beneficiary’s primary or other physician to see a specialist or receive certain services.

Regional Home Health Intermediary (RHHI) - organization that contracts with Medicare to pay home health bills and to audit home health physicians.

Regional Office - the Centers for Medicare & Medicaid Services (CMS) has 10 Regional Offices that work closely together with Medicare Contractors in their assigned geographical areas on a day-to-day basis. Four of these Regional Offices monitor network contractor performance, negotiate contractor budgets, distribute administrative monies to contractors, work with contractors when corrective actions are needed, and provide a variety of other liaison services to the contractors in their respective regions.

Rejection - the claim was not processed for payment and was returned to the provider due to missing or incorrect elements.

Relative Value - reflects the relativity in units of median charges among procedures, in any of the five major categories of medicine.

Relator - a person who files a qui tam suit on behalf of the Government; see “Qui Tam” or Whistle Blower.

Remittance - the payment of a Medicare claim by a Medicare Contractor.

Remittance Advice (RA) - a statement sent to providers that explains the reimbursement decision made by the payment Contractor; this explanation may include the reasons for payments, denials, and/or adjustments for processed claims. Also serves as a companion to claim payments.

Resident - for Medicare purposes, a physician who is participating in an approved Graduate Medical Education (GME) training program or one who is not in an approved program but who is authorized to practice only in a hospital setting.

Restitution - a court-ordered giving or returning of funds.

Review - 1) an independent, critical examination of a claim made as a result of an appeal; 2) an administrative process that results when an “aggrieved party” challenges a coverage policy such as a Local Coverage Determination (LCD) or National Coverage Determination (NCD).

Rights - Medicare beneficiaries are guaranteed certain rights or protections including: privacy; treatment options; itemized Statements; information regarding treatments; access to needed services; and appeals.

S

Sanction - a situation or condition where coverage is disallowed by a subscriber’s contract; Department of Health and Human Services (HHS)/Office of Inspector General (OIG) penalty imposed on a provider, prohibiting the individual from billing Medicare or other Government programs.

Sanctioned Provider List - an Office of Inspector General (OIG) list of providers, individuals, and entities that are excluded from Medicare reimbursement; includes identifying information about the sanctioned party, specialty, notice date, sanction period, and sections of the Social Security Act used in arriving at the determination to impose a sanction.

Screening Test - an examination for early detection of a specific disease; Medicare pays for specific routine screenings, such as Pap tests, mammograms, prostate cancer screenings, and colorectal cancer screenings.

Services - procedures furnished that are represented by Current Procedural Terminology (CPT) or Health Care Common Procedure Coding System Codes on a claim.

Skilled Nursing Facility (SNF) - an institution or distinct part of an institution having a transfer agreement with one or more hospitals; primarily engaged in providing inpatient skilled nursing care or rehabilitation services.

Social Security Administration (SSA) - the federal agency that administers various programs funded under the Social Security Act; determines eligibility for Medicare benefits.

Speech-Language Pathology - services provided within the scope of practice of speech-language pathologists and necessary for the diagnosis and treatment of speech and language disorders, which result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability.

State Health Insurance Assistance Program (SHIP) - local specially-trained staff and volunteer counselors that provide personal health insurance counseling to beneficiaries. Services are free, unbiased, and confidential.

Supplier - an entity that provides Durable Medical Equipment (DME) or items such as a wheelchair or portable X-ray machine.

Supplies - devices or equipment that provide a health benefit.

Supplemental Insurance - a policy purchased by a beneficiary to help pay charges, such as deductibles, coinsurance, and excluded services, that Medicare does not pay.

T

Title XVIII of the Social Security Act - the statutory authority for the Medicare Program.

Title XIX of the Social Security Act - the statutory authority for the Medicaid Program.

Treatment - the action taken to address or prevent a health problem.

U

Unbundled Service - a service that is considered part of the basic allowance of another procedure, but that is billed separately to Medicare. Medicare does not allow billing for incorrect unbundled services.

Unique Physician/Practitioner Identification Number (UPIN) - a 6-character alphanumeric code, assigned by the Centers for Medicare & Medicaid Services (CMS) to each Medicare provider and used to identify a referring physician. This number is NEVER used as a provider billing number.

United States - for Medicare coverage purposes, the term United States means the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. For purposes of services furnished on a ship, it includes the territorial waters adjoining the land areas of the United States.

Unprocessable Claim - a claim that cannot be processed due to certain incomplete or incorrect information.

Upcoding - a potentially fraudulent activity that involves claims submitted to Medicare for non-covered/non-chargeable services, supplies, or equipment in a way that makes it appear that Medicare covered services, supplies, or equipment were provided.

Utilization - the percentage of usage by Medicare patients of a particular facility's or health care provider's services.

Utilization Review - the process of verifying medical necessity of services furnished or ordered by a physician or other provider.

V

Vendor - an individual or entity that provides hardware, software, and/or ongoing support services for providers to file claims electronically to Medicare.

W

"Welcome to Medicare" Physical Exam - a comprehensive initial preventive physical examination provided by Medicare to assess risk factors for disease. The "Welcome to Medicare" Physical Exam is available to all beneficiaries who begin their Medicare coverage on or after January 1, 2005, and must be provided within the first 6 months of coverage. It is the Initial Preventive Physical Examination (IPPE) or the "Welcome to Medicare" physical exam or visit.

Whistle Blower - the "Whistle Blower" or "qui tam" provision allows any person having knowledge of a false claim against the Government to bring an action against the suspected wrongdoer on behalf of the United States Government. A person who files a qui tam suit on behalf of the Government is known as a "relator" and may share a percentage of the recovery realized from a successful action.

REFERENCE J: ACRONYMS

ABN	Advance Beneficiary Notice
ADA	American Dental Association
ADL	Activity of Daily Living
ADR	Additional Documentation Request
AHA	American Hospital Association
ALJ	Administrative Law Judge
ALS	Advanced Life Support
ALS	Amyotropic Lateral Sclerosis
AMA	American Medical Association
ANSI	American National Standards Institute
ARNP	Advanced Registered Nurse Practitioner
ASC	Accredited Standards Committee
ASC	Ambulatory Surgical Center
ASCA	Administrative Simplification Compliance Act
BBA	Balanced Budget Act
BCBS	Blue Cross Blue Shield
BCBSA	Blue Cross Blue Shield Association
BIPA	Benefits Improvement and Protection Act
BL	Black Lung
BNI	Beneficiary Notices Initiative
CAH	Critical Access Hospital
CAP	Corrective Action Plan
CAPD	Continuous Ambulatory Peritoneal Dialysis
CARC	Claim Adjustment Reason Codes
CBSA	Core Based Statistical Area
CCI	Correct Coding Initiative
CCN	Correspondence Control Number
CCPD	Continuous Cycling Peritoneal Dialysis
CDC	Centers for Disease Control and Prevention
CDI	Chronically Dependent Individual
CDT	Current Dental Terminology
CEO	Chief Executive Officer
CERT	Comprehensive Error Rate Testing
CF	Conversion Factor
CHOW	Change of Ownership
CLIA	Clinical Laboratory Improvement Amendments
CMHC	Community Mental Health Center
CMN	Certificate of Medical Necessity
CMP	Civil Monetary Penalty
CMPL	Civil Monetary Penalty Law
CMS	Centers for Medicare & Medicaid Services
CMSPCS	Centers for Medicare & Medicaid Services Procedure Coding System
CNS	Clinical Nurse Specialist
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
COPD	Chronic Obstructive Pulmonary Disease
CORF	Comprehensive Outpatient Rehabilitation Facility

CP	Cerebral Palsy
CPEP	Clinical Practice Expert Panel
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
CT	Computed Tomography
CWF	Common Working File
CY	Calendar Year
DAB	Departmental Appeals Board
DCN	Document Control Number
DGME	Direct Graduate Medical Education
DHEW	Department of Health, Education, and Welfare
DHHS	Department of Health and Human Services
DHS	Disproportionate Share Hospital
DME	Durable Medical Equipment
DMERC	Durable Medical Equipment Regional Carrier
DO	Doctor of Osteopathy
DOJ	Department of Justice
DRG	Diagnosis Related Group
DRE	Digital Rectal Examination
DSH	Disproportionate Share Hospital
DSMO	Designated Standards Maintenance Organizations
DSMT	Diabetes Self Management Training
DVA	Department of Veterans Affairs
EACH	Essential Access Community Hospital
E-Code	External Cause of Injury Code
ECS	Electronic Claims Status
EDI	Electronic Data Interchange
EEG	Electroencephalogram
EFT	Electronic Funds Transfer
EGHP	Employee Group Health Plan
EIN	Employer Identification Number
EKG	Electrocardiogram
E/M	Evaluation & Management
EMC	Electronic Media Claims
EMTALA	Emergency Medical Treatment and Labor Act
EOB	Explanation of Benefits
EPO	Epoetin
EPLS	Excluded Parties Listing System
ERA	Electronic Remittance Advice
ESRD	End Stage Renal Disease
ESWT	Extra-Corporeal Shock Wave Therapy
FARs/DFARS	Federal Acquisition Regulations/Defense Acquisition Regulations Supplement
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FI	Fiscal Intermediary
FISS	Fiscal Intermediary Shared System
FL	Field Locator
FLP	Financial Liability Protection
FMR	Focused Medical Review

FQHC	Federally Qualified Health Center
FYE	Fiscal Year End
GBA	Government Benefits Administrator
GHP	Group Health Plan
GME	Graduate Medical Education
GPCI	Geographic Practice Cost Index
GPO	Government Printing Office
GSA	General Services Administration
HCFA	Health Care Financing Administration
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HHABN	Home Health Advance Beneficiary Notice
HI	Hospital Insurance
HIAA	Health Insurance Association of America
HIC or HICN	Health Insurance Claim Number
HINN	Hospital-Issued Notice of Non-Coverage
HIPAA	Health Insurance Portability and Accountability Act
HIPPS	Health Insurance Prospective Payment System
HMO	Health Maintenance Organization
HO	Hearing Officer
HPSA	Health Professional Shortage Area
ICD-9-CM	International Classification of Disease, 9th Revision, Clinical Modification
ICF	Intermediate Care Facility
ICN	Internal Control Number
IDE	Investigational Device Exemption
IDTF	Independent Diagnostic Testing Facilities
IHS	Indian Health Services
IM	Important Message from Medicare
IME	Indirect Medical Education
IPPE	Initial Preventive Physical Examination
IRF	Inpatient Rehabilitation Facility
IRP	Incentive Reward Program
IRS	Internal Revenue Service
IT	Information Technology
LCD	Local Coverage Determination
LCSW	Licensed Clinical Social Worker
LEIE	List of Excluded Individuals/Entities
LGHP	Large Group Health Plan
LMRP	Local Medical Review Policy
LOL	Limitation on Liability
LPN	Licensed Practical Nurse
LRD	Lifetime Reserve Day
LTC-DRG	Long Term Care - Diagnosis Related Group
LTCH	Long Term Care Hospital
LTR	Lifetime Reserve
MAC	Medicare Administrative Contractor
MCE	Medicare Code Editor
MCR	Medicare Contracting Reform
MD	Doctor of Medicine
MDC	Major Diagnostic Category

MEDPARD	Medicare Participating Physician/Supplier Directory
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MNT	Medical Nutrition Therapy
MPFS	Medicare Physician Fee Schedule
MR	Medical Review
MRA	Magnetic Resonance Angiography
MRI	Magnetic Resonance Imaging
MRN	Medicare Remittance Notice
MS	Multiple Sclerosis
MSA	Medical Savings Account
MSP	Medicare Secondary Payer
MSN	Medicare Summary Notice
MTF	Military Treatment Facility
N/A	Not Applicable
NCCI	National Correct Coding Initiative
NCD	National Coverage Determination
NDC	National Drug Code
NEMB	Notice of Exclusions of Medical Benefits
NMES	Neuromuscular Electrical Stimulation
NOC	Not Otherwise Classified
NODMAR	Notice of Discharge and Medicare Appeals Rights
NONMC	Notice of Medicare Non-Coverage
NP	Nurse Practitioner
NPI	National Provider Identifier
NPWP	Negative Pressure Wound Therapy
NSC	National Supplier Clearinghouse
NSF	National Standard Format
NUBC	National Uniform Billing Committee
N&AH	Nursing and Allied Health
OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCR	Optical Character Recognition
OCR	Office for Civil Rights
OHA	Office of Hearing and Appeals
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMHA	Office of Medicare Hearings and Appeals
OPPS	Outpatient Prospective Payment System
OPT	Outpatient Physical Therapy
ORF	Outpatient Rehabilitation Facility
OSCAR	Online Survey Certification and Reporting
OTF	Outpatient Therapy Facility
OTR	On-The-Record
PA	Physician Assistant
PAT	Pre-Admission Testing
PCA	Progressive Corrective Action
PCS	Provider Claim Summary
PCN	Patient Control Number
PDF	Portable Document Format
PHI	Protected Health Information

PHS	Public Health Service
PI	Program Integrity
PIN	Provider Identification Number
PIP	Periodic Interim Payment
POC	Plan of Care
POS	Place of Service OR Point of Service (with Medicare Advantage Plans)
POTR	Preliminary On-The-Record
POV	Power Operated Vehicle
PPO	Preferred Provider Organization
PPR	Physician Payment Reform
PPS	Prospective Payment System
PPV	Pneumonia/Influenza Vaccine
PSC	Program Safeguard Contractor
PSO	Provider Sponsored Organization
PTS	Provider Tracking System
QA	Quality Assurance
QC	Quarter of Coverage
QDWI	Qualified Disabled and Working Individual
QIC	Qualified Independent Contractor
QIO	Quality Improvement Organization
QMB	Qualified Medicare Beneficiary
RA	Remittance Advice
RAP	Request for Anticipated Payment
RARC	Remittance Advice Remark Codes
RBRVU	Resource-Based Relative Value Unit
RDF	Renal Dialysis Facility
RFP	Religious Fraternal Benefit Society Plan
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RN	Registered Nurse
RPCH	Rural Primary Care Hospital
RR	Refund Requirement
RRB	Railroad Retirement Board
RTC	Residential Treatment Center
RTP	Return to Provider
RUG	Resource Utilization Grouping
RVU	Relative Value Unit
SADMERC	Statistical Analysis DME Regional Carrier
SCD	Secondary Claim Development
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SDO	Standards Development Organization
SEP	Special Enrollment Period
SHIP	State Health Insurance Program
SLMB	Specified Low-income Medicare Beneficiary
SMI	Supplementary Medical Insurance
SNF	Skilled Nursing Facility
SOF	Signature on File
SPL	Speech Language Pathology
SPR	Standard Paper Remittance

SRS	Social and Rehabilitation Service
SSA	Social Security Administration
SSN	Social Security Number
SUBC	State Uniform Billing Committee
TB	Tuberculosis
TBD	To Be Determined
TIN	Tax Identification Number
TOB	Type of Bill
TTY/TDD	Teletype/Telecommunications Device for the Deaf
UMW	United Mine Workers
UPIN	Unique Physician Identification Number
UR	Utilization Review
VA	Veterans Affairs
VHA	Veterans Health Administration
WC	Workers' Compensation
WCMSA	Workers' Compensation Medicare Set-Aside Arrangement
WHO	World Health Organization

REFERENCE K: WEBSITES AND PHONE NUMBERS

Please note that all information listed below was accurate per the Centers for Medicare & Medicaid Services (CMS) website, and other related websites, at the time of printing; however, this information is subject to change.

Website References	
Disclaimer	
Medicare Learning Network (MLN) Web Page	*www.cms.hhs.gov/MLNGenInfo*
Foreword	
CMS Regional Office Contact Information	*www.cms.hhs.gov/RegionalOffices*
Preface	
Reference Guide for Medicare Physician & Supplier Billers	*www.cms.hhs.gov/MLNProducts*
Section 1: Introduction to Medicare	
2003 Medicare Legislation and Policies	*www.cms.hhs.gov/MMAupdate/*
Compare Medicare Prescription Drug Plans	*www.medicare.gov* **OR** *www.cms.hhs.gov/PrescriptionDrugCovGenIn/03_Resources.asp*
Medicare Hospice Benefits	*www.medicare.gov/publications/pubs/pdf/02154.pdf*
Therapy Services Information	*www.cms.hhs.gov/TherapyServices/*
Preventive Services Information	*www.cms.hhs.gov/PrevntionGenInfo/*
Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Information	*www.medicare.gov/medicarereform* **OR** *www.cms.hhs.gov/MMAUpdate/*
Medicare Advantage Payment Rates	*www.cms.hhs.gov/MedicareAdvtgSpecRateStats/*
Medicare Managed Care Fast Track Appeals and Grievance Information	*www.cms.hhs.gov/MMCAG/*

Website References	
Section 1: Introduction to Medicare (Con't)	
Directory of Fiscal Intermediaries (FIs) and Carriers	*www.cms.hhs.gov/apps/contacts/incardir.asp* The contacts database is the primary source for all contact information on the CMS website. It is verified quarterly and updated on a monthly basis.
Medicare Contracting Reform (MCR) Information	*www.cms.hhs.gov/MedicareContractingReform/*
Medicare Eligibility Tool	*www.medicare.gov/MedicareEligibility/home.asp?version=default&browser=IE%7C6%7CWinXP&language=English*
Your Medicare Rights and Protections	*www.medicare.gov/Publications/Pubs/pdf/10112.pdf*
Compare Health Plan Options in Your Area	*www.medicare.gov/Help/mppf.asp* **OR** *www.medicare.gov/MPPF/Include/DataSection/Questions/Welcome.asp*
MLN Matters Articles, Specialized Links to Federal Regulations, Program Transmittals, Frequently Asked Questions, and ListServs	*www.cms.hhs.gov/center/provider.asp*
Provider-specific Information	*www.cms.hhs.gov/center/provider.asp*
Coverage and Payment Policy, Billing, Contacts, and Frequently Asked Questions (FAQs)	*www.cms.hhs.gov/* **OR** *www.cms.hhs.gov/home/medicare.asp*
MLN Matters Articles Containing Claims Processing Information	*www.cms.hhs.gov/MLNMattersArticles*
Medicare Coordination of Benefits (COB) Contractor Information	*www.cms.hhs.gov/COBGeneralInformation/03_ContactingtheCOBContractor.asp*
Basic Medicare Information and Beneficiary	*www.medicare.gov*

Website References	
Section 2: Becoming a Medicare Provider	
List of State Agencies	*www.cms.hhs.gov/SurveyCertificationGenInfo/03_Contact%20Information.asp*
State Operations Manual	*www.cms.hhs.gov/Manuals/IOM/list.asp* Search for publication #100-07.
General State Certification, Provider Enrollment and Enrollment Status Information	*www.cms.hhs.gov/MedicareProviderSupEnroll/*
CMS Provider Enrollment Forms and Guidance for Completing These Forms	*www.cms.hhs.gov/MedicareProviderSupEnroll/03_Enrollment Applications.asp*
Adobe Systems Incorporated Website; Provides a Free Download of the Adobe Reader for Portable Document Format (PDF) Documents	*www.adobe.com*
List of Local Contractors	*www.cms.hhs.gov/MedicareProviderSupEnroll/PSEC/list.asp*
Section 3: Submitting Medicare Claims	
Form CMS-1450 Information and Downloadable Form	*www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp*
Form CMS-1450 Printing Information	*www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp*
Additional Information on the CMS-1450 Form	*http://bookstore.gpo.gov/*
Medicare Program Integrity Manual and Completing Certificates of Medical Necessity (CMNs)	*www.cms.hhs.gov/Manuals/IOM/list.asp* Search for publication #100-08.
Local Fiscal Intermediary (FI) Electronic Data Interchange (EDI) Help Lines	*www.cms.hhs.gov/ElectronicBillingEDITrans/03_EDISupport.asp*

Website References	
Section 3: Submitting Medicare Claims (Con't)	
Information Regarding the CMS Electronic Data Interchange (EDI) Standard Enrollment Form	*www.cms.hhs.gov/ElectronicBillingEDITrans/03_EnrollInEDI.asp*
The CMS Electronic Data Interchange (EDI) Standard Enrollment Form PDF	*www.cms.hhs.gov/CMSForms/CMSForms/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019477*
Sample Secondary Claim Development (SCD) Questionnaires	*www.cms.hhs.gov/InsurerServices/04_medicaresecclaimdevquest.asp*
Medicare Coverage of Kidney Dialysis and Kidney Transplant Services	*www.medicare.gov/publications/pubs/pdf/10128.pdf*
Medicare Benefit Policy Manual	*www.cms.hhs.gov/Manuals/IOM/list.asp* Search for publication #100-02.
Medicare Secondary Payer Manual and Provider Billing Requirements	*www.cms.hhs.gov/Manuals/IOM/list.asp* Search for publication #100-05.
Submitting Workers' Compensation Medicare Set-aside Arrangements (WCMSAs)	*www.cms.hhs.gov/WorkersCompAgencyServices/04_wcsetaside.asp*
Part A Other Insurer Intake Tool	*www.cms.hhs.gov/ProviderServices/04_PartAOtherInsurerIntakeTool.asp*
Part B Other Insurer Data Gathering Tool	*www.cms.hhs.gov/ProviderServices/05_%20PartBOtherInsurerIntakeTool.asp*
Medicare Secondary Payer Manual	*www.cms.hhs.gov/Manuals/IOM/list.asp* Search for publication #100-05.

Website References	
Section 3: Submitting Medicare Claims (Con't)	
Medicare and Other Health Benefits: Your Guide to Who Pays First	*www.medicare.gov/publications/pubs/pdf/02179.pdf*
Frequently Asked Questions (FAQs) about Coordination of Benefits (COB) or Medicare Secondary Payer (MSP)	*questions.cms.hhs.gov/* Use search term "Coordination of Benefits", "COB", "Medicare Secondary Payer", or "MSP".
Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers	*www.cms.hhs.gov/MLNProducts*
Latest Health Care Claim Adjustment Reason Codes and Remittance Advice (RA) Remark Codes	*www.wpc-edi.com/codes*
Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) Information	*www.wpc-edi.com/codes/codes.asp*
Beneficiaries Notification Initiative (BNI), Financial Liability Protection (FLP) Notices, and Current Advance Beneficiary Notification (ABN) Forms	*www.cms.hhs.gov/BNI/* **OR** *www.cms.hhs.gov/Manuals/IOM/list.asp* Search for publication #100-04.
Notice of Exclusions from Medicare Benefits (NEMB) Form	*www.cms.hhs.gov/BNI/*
Section 4: Protecting Medicare from Fraud and Abuse	
Medicare Program Integrity Manual and Contractor Medical Review (MR) Requirements and MR Process Information	*www.cms.hhs.gov/Manuals/IOM/list.asp* Search for publication #100-08.

Website References	
Section 4: Protecting Medicare from Fraud and Abuse (Con't)	
Current National Coverage Determinations (NCDs)	*www.cms.hhs.gov/mcd/search.asp*
Medicare National Coverage Determinations Manual	*www.cms.hhs.gov/Manuals/IOM/list.asp* Search for publication #100-03.
Draft and Final Local Coverage Determinations (LCDs)	*www.cms.hhs.gov/mcd/search.asp*
Comprehensive Error Rate Testing (CERT) Provider Website Home Page	*www.cms.hhs.gov/CERT/* **OR** *www.certcdc.com/certproviderportal*
Medicare Program Integrity Manual	*www.cms.hhs.gov/Manuals/IOM/list.asp* Search for publication #100-08.
Section 5: Protecting Medicare from Fraud and Abuse	
Medicare Resident & New Physician Guide and Examples of Medicare Abuse	*www.cms.hhs.gov/MLNProducts*
Provider Enrollment Forms and Information	*www.cms.hhs.gov/MedicareProviderSupEnroll/03_Enrollment Applications.asp*
Department of Health and Human Services (HHS) Office of Inspector General (OIG) Exclusion Program	*www.oig.hhs.gov/fraud/exclusions.html*
The OIG Sanctioned List of Excluded Individuals/Entities (LEIE)	*www.oig.hhs.gov/fraud/exclusions.html*
General Services Administration (GSA) Disbarred/Excluded/Suspended Parties List (EPLS)	*http://epls.arnet.gov*

Website References	
Section 5: Protecting Medicare from Fraud and Abuse (Con't)	
Medicare Program Integrity Manual and Incentive Reward Program (IRP) Information	*www.cms.hhs.gov/Manuals/IOM/list.asp* Search for publication #100-08.
Section 6: Troubleshooting Denials and Claim Rejections	
Medicare Claims Processing Manual and Form CMS-1450 Crosswalk Between Electronic and Paper Claim Forms	*www.cms.hhs.gov/Manuals/IOM/list.asp* Search for publication #100-04.
UPIN Directory	*www.upinregistry.com*
Information on Applying for and using the National Provider Identifier (NPI) and NPI Final Rules	*www.cms.hhs.gov/NationalProvIdentStand/*
National Provider Identifier (NPI) Application and Educational Tool	*https://nppes.cms.hhs.gov/NPPES/Welcome.do*
Latest Claim Adjustment Reason Codes and Remittance Advice (RA) Remark Codes	*www.wpc-edi.com/codes*
Social Security Administration (SSA) Coverage Policy Denial Information	*www.ssa.gov/OP_Home/ssact/title18/1862.htm*
Fiscal Intermediary Shared System (FISS) Information and Workbook	*www.iamedicare.com/Provider/newsroom/refguide/fiss_workbook.pdf*
Social Security Administration (SSA) Medical Necessity Denial Information	*www.ssa.gov/OP_Home/ssact/title18/1862.htm*

Website References	
Section 7: Appealing Medicare Claim Denials	
Updated Appeals Policy Interim Final Rule of March 8, 2005	*www.cms.hhs.gov/quarterlyproviderupdates/downloads/CMS4064IFC.pdf*
Correcting Amendment for Interim Final Rule	*www.cms.hhs.gov/quarterlyproviderupdates/downloads/CMS4064IFC2.pdf*
Medicare Management Care Fast Track Appeals and Grievance Information	*www.cms.hhs.gov/MMCAG/*
Notice of Discharge and Medicare Appeals Rights (NODMAR) Information	*www.cms.hhs.gov/bni*
Correcting Minor Claims Errors/Omissions	*www.cms.hhs.gov/MLNMattersArticles* Search for MLN article SE0420.
Transfer of Appeals Rights Form (Form CMS-20031)	*www.cms.hhs.gov/cmsforms/downloads/cms20031.pdf*
Qualified Independent Contractor (QIC) Information	*www.cms.hhs.gov/quarterlyproviderupdates/downloads/CMS4050NR.pdf*
Medicare Redetermination Request Form (Form CMS-20027)	*www.cms.hhs.gov/cmsforms/downloads/cms20027.pdf*
Medicare Reconsideration Request Form (Form CMS-20033)	*www.cms.hhs.gov/cmsforms/downloads/cms20033.pdf*
Request For Review of Administrative Law Judge (ALJ) Medicare Decision/ Dismissal Form (Form CMS-20034A/B)	*www.cms.hhs.gov/cmsforms/downloads/cms20034ab.pdf*
Request for Review of Administrative Law Judge Medicare Decision/Order Form (Form DAB-101)	*www.hhs.gov/dab/DAB101.pdf*

Website References	
Section 7: Appealing Medicare Claim Denials (Con't)	
Medicare Programs: Changes to the Medicare Claims Appeal Procedures Interim Final Rule	*www.cms.hhs.gov/quarterlyproviderupdates/downloads/CMS4064IFC.pdf*
Information for Challenging an LCD or a National Coverage Determination (NCD)	*www.cms.hhs.gov/Rulings/downloads/CMSR0101.pdf*
Section 8: Introduction to HIPAA	
Covered Entity Decision Tools	*www.cms.hhs.gov/HIPAAGenInfo/06_AreYouaCoveredEntity.asp*
Contact Information for HHS Office for Civil Rights (OCR) HIPAA	*www.hhs.gov/ocr/hipaa/*
HIPAA Health Insurance Portability and Accountability Act of 1996 (HIPAA) Requirements and Coverage Information	*www.cms.hhs.gov/HIPAAGenInfo/01_Overview.asp*
HIPAA Administrative Simplification - Transaction Regulations and Standards, Final Rules, Code Sets, and Identifier Information	*www.cms.hhs.gov/HIPAAGenInfo/*
HIPAA Implementation Guides	*www.wpc-edi.com/hipaa/HIPAA_40.asp*
Medicare Resident and New Physician Guide and Evaluation and Management Service (E/M) Codes and Documentation Guidelines for Using E/M Codes	*www.cms.hhs.gov/MLNProducts/MPUB/list.asp*
Designated Standards Maintenance Organization (DSMO) Modification Process Information	*www.hipaa-dsmo.org/*

Website References	
Section 8: Introduction to HIPAA (Con't)	
Full Listing of Healthcare Common Procedure Coding System (HCPCS) Codes [Including Current Procedural Terminology (CPT) Codes]	*www.cms.hhs.gov/HCPCSReleaseCodeSets*
Latest Claims Adjustment Reason Codes and RA Remark Codes	*www.wpc-edi.com/codes/*
Latest Medicare Electronic Billing Requirements	*www.cms.hhs.gov/ElectronicBillingEDITrans/01_overview.asp*
Latest Regulations Regarding Limited Acceptance of Paper Claims	*www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp*
Contingency Planning Guidelines	*www.cms.hhs.gov/ElectronicBillingEDITrans/17_Contingency.asp*
HIPAA Security Educational Papers and Security Standards Information	*www.cms.hhs.gov/EducationMaterials/04_SecurityMaterials.asp*
HIPAA Final Rule for Security Standards	*www.cms.hhs.gov/SecurityStandard/Downloads/securityfinalrule.pdf*
Unique Identifier Information	*www.cms.hhs.gov/NationalProvIdentStand/01_overview.asp*
HIPAA Final Rule for Privacy Standards	*www.hhs.gov/ocr/hipaa/privrulepd.pdf*
HIPAA Privacy Rule Implementation for the Medicare Program and Privacy Policy Compliance Information	*www.cms.hhs.gov/HIPAAGenInfo/Downloads/Implementation.pdf*

Website References	
Section 8: Introduction to HIPAA (Con't)	
HIPAA Impact on Alcohol and Drug Abuse Programs	*www.hipaa.samhsa.gov/part2comparisoncleared.htm*
Privacy Policy Compliance Information	*www.cms.hhs.gov/HIPAAGenInfo/04_PrivacyStandards.asp*
Privacy Rule in Relation to Law Enforcement	*www.hhs.gov/ocr/hipaa/*
HIPAA Standards Enforcement Information	*www.hhs.gov/ocr/combinedregtext.pdf* **OR** *www.cms.hhs.gov/Enforcement/04_GeneralEnforcement Information.asp*
HIPAA Administrative Simplification: Enforcement Final Rule	*www.hhs.gov/ocr/hipaa/FinalEnforcementRule06.pdf*
Reference A: Form CMS 1450	
Latest Healthcare Common Procedure Coding System (HCPCS) Codes	*www.cms.hhs.gov/HCPCSReleaseCodeSets*
Form CMS-1450 in PDF	*www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp*
Medicare Claims Processing Manual and Latest CMS Billing and Coding Requirements	*www.cms.hhs.gov/Manuals/IOM/list.asp* Search for publication #100-04.
NPI Implementation	*www.cms.hhs.gov/NationalProvidentStand/*
Reference B: Form CMS-1450 (UB-92) - Electronic Claim Form Crosswalk	
Electronic Claim Form Crosswalk	*www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp*
Medicare Claims Processing Manual and Instructions for Completing the CMS-1450 Form	*www.cms.hhs.gov/Manuals/IOM/list.asp* Search for publication #100-04.

Website References	
Reference B: Form CMS-1450 (UB-92) - Electronic Claim Form Crosswalk (Con't)	
Updates to the *HIPAA X12N 837 Health Care Claim Implementation Guide*	*www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp*
Reference C: Type of Bill (TOB) Codes	
State Operations Manual and Definition of Facility Types	*www.cms.hhs.gov/Manuals/IOM/list.asp* Search for publication #100-07.

Address and Phone Number References

Where to Find Telephone Contact Information on the CMS Website:

Contact information for entities such as Fiscal Intermediaries (FIs) and Regional Home Health Intermediaries (RHHIs), is available at *www.cms.hhs.gov/apps/contacts/incardir.asp* on the CMS website.

Please note that all information listed below was accurate per the CMS website and other related websites at the time of printing; however, this information is subject to change.

Section 1: Introduction to Medicare		
Subject	**Office/Company and Address**	**Phone Number/Email**
Medicare Policy and Claims Processing Information	N/A	1-800-999-1118 TTY/TDD: 1-800-318-8782
Medicare Beneficiary, State Health Insurance Assistance Program (SHIP), Prescription Drug Card Resources, and Availability of "Medicare Savings" Programs	N/A	1-800-MEDICARE (1-800-633-4227) TTY/TDD: 1-877-486-2048
Medicare Eligibility and Enrollment Information	N/A	1-800-772-1213 TTY/TDD: 1-800-325-0778
Section 3: Submitting Medicare Claims		
Subject	**Office/Company and Address**	**Phone Number/Email**
Government Printing Office (GPO) for Form CMS-1450 Claim Forms	Superintendent of Documents P.O. Box 371954 Pittsburg, PA 15250-7954	1-866-512-1800 202-512-1800 in the Washington, DC Metropolitan Area

Section 3: Submitting Medicare Claims (Con't)		
Subject	**Office/Company and Address**	**Phone Number/Email**
Where to Submit Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Proposals for Review	CMS C/O Coordination of Benefits Contractor P.O. Box 660 New York, NY 10274-0660 Attn: WCMSA Proposal	
Medicare Coordination of Benefits (COB) Contractor and Medicare Secondary Payer (MSP) Information	MEDICARE - Coordination of Benefits P.O. Box 5041 New York, NY 10274-5041	1-800-999-1118 TTY/TDD: 1-800-318-8782
CMS E-mail Address for Submission of MSP Questions and Comments		*mspcentral@cms.hhs.gov*
Section 4: Protecting Medicare from Fraud and Abuse		
Subject	**Office/Company and Address**	**Phone Number/Email**
Report or Ask Questions About Medicare Fraud and Abuse	N/A	1-800-HHS-TIPS (1-800-447-8477) TTY/TDD: 1-800-377-4950
Section 5: Troubleshooting Denials and Claim Rejections		
Subject	**Office/Company and Address**	**Phone Number/Email**
Ask Durable Medical Equipment Regional Carrier (DMERC) Coding Questions	N/A	1-877-735-1326
Submitting a Department of Appeals Board Request	Depart of Health and Human Services Depart of Appeals Board, MS 6127 Medicare Appeals Council 300 Independence Avenue, SW Room G-644 Washington, DC 20201	Fax Request: 202-565-0227 Inquiries: 202-565-0100
Challenging an LCD or NCD	N/A	1-800-MEDICARE (1-800-633-4227) TTY/TDD: 1-877-486-2048

Section 6: Introduction to HIPAA		
Subject	**Office/Company and Address**	**Phone Number/Email**
HIPAA Requirements, Coverage, and Privacy Policy Compliance Information	N/A	1-866-282-0659 TTY/TDD: 1-877-326-1166


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